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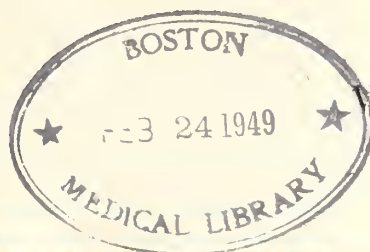
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The Journal of the South Carolina Medical Association

JANUARY, 1949



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CONTENTS

One Hundred Years

O. B. Chamberlain, M. D.

Saddle Block Anesthesia In Obstetrics Report Of 235 Consecutive Cases

Rowland F. Zeigler, Jr., M. D., F.A.C.S.

The Technic Of Saddle Block Analgesia In Obstetrics

William Melver Bryan, Jr., M. D.

The Use Of Pentothal As A General Anesthetic In Vaginal Delivery

R. Brooks Scurry, M. D.

**Editorials — The Ten Point Program — Abstracts — Woman's Auxiliary —
Deaths — News Items**

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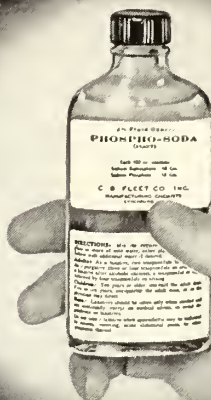
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The Journal

of the

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VOLUME XLV

January, 1949

NUMBER 1

One Hundred Years

O. B. CHAMBERLAIN, M. D.
Charleston, S. C.

A presidential address by custom, is an attempt to present and comment upon the "state of the Union." Anyone who would set out in the field of medicine to pursue such a course in this the year 1948 would indeed be brave. While it is true that each generation and age regards its particular problems as critical, those of us who are present today are, by common consent, in the most extraordinary age the world has ever known. For the first time in his career, man has produced a Frankenstein capable of instantly destroying the entire race, and leaving this planet bare of human life to begin anew the evolution of a dominant species. The idea is staggering and its implications awe-inspiring. Perhaps the tragic and somber thoughts engendered by the contemplation of our danger will sober us into a realization of the necessity of developing our emotional control as we have developed our intellectual power. The present national news and the prevalent world tension does not as yet give much promise of that happy solution. But we shall continue to hope because otherwise there is little light. Some one has noted that a French diarist of one hundred years ago quotes the scientist Berthelot as making this startling prophecy, "In a hundred years man with his ingenious mind will divide the atom, and shortly thereafter God will come down from Heaven, jingling his keys and saying, 'All right, gentlemen, it's just about closing time.'" Let us fervently trust that the latter part of this prophecy does not prove as accurate as the first.

Our meeting commemorates one hundred years of our organized life. I shall not attempt to summarize the events of those years. Our much esteemed colleague, Joe Waring, who has done yeoman's work in preparation for this celebration, has performed a magnificent service to our Association by writing a history of these one hundred years of progress. You

have received or will receive a copy of this accurate and scholarly work.

The problems of 1848 were different from our problems. The practice of medicine was concerned mainly with the relief of symptoms, in pioneer communities. The corner stones of our present science of medicine was virtually unknown. During these past one hundred years were to come the discoveries of cellular pathology, microscopic anatomy and pathology, bio-chemistry and physiology, and, most important of all, bacteriology. This last, combined with anesthesia, gave rise to aseptic surgery, and the ability to explore all parts of the human body with comparative safety. Finally the last few decades has produced discoveries which has led to a knowledge of hormones, with an insight into the nervous and chemical integration of the body. We are now beginning to grasp the concept of the body as a whole, and to understand how, as some one has put it, "fear and resentment can produce ulcers."

Running on parallel tracks, as it were, with this progress in the scientific knowledge of disease, has been the changes of the social aspect of medical practice. Many of us would hesitate to use the word "advances" in this particular aspect of our review.

The doctor of 1848 and his patient were singularly "on their own." Hospitals were unknown, except as poor houses, and pest houses. Clinics, laboratory help, auxiliary aids in diagnosis were years in the future. The concept of community, or national responsibility was dim indeed. Boards of health, if existent at all, consisted of committees without funds or plans of procedure. There was no state aid, and federal aid was in the dim and distant future. The high cost of medical care had not as yet become a problem. Let us visualize a South Carolina physician of 1848 who confronted a problem in the baffling illness of the daughter of a prosperous planter. Let us say the doctor lived in Darlington. He would very probably have consulted the learned and scholarly Dr. Moultrie, dean of the

(Presidential address, delivered at Centennial Meeting, Charleston).

faculty of medicine at the Medical College of South Carolina. Non-plussed, that gentleman might well have suggested the Americas' greatest figure, the elder deCosta of Philadelphia. A sea-voyage finally brought our patient to Philadelphia the center of American Medicine. In a short half hour, this distinguished gentleman could have exhausted all modes of inquiry. Besides his own senses, the worthy consultant had one crude help only. He could inspect, and taste, the urine. In 1848, a fee of twenty-five or fifty dollars would be an excellent return for a half-hour's interview with the doctor, whose office consisted of one or two rooms in the ground floor of his brown brick house on Walnut Street. And so the girl from South Carolina would receive all that American Medicine could offer for twenty-five dollars and the expenses of her trip. The cost of treatment was generally in terms of travel. Doctors prescribed balmy climates, and stimulating climates, dry climates and moist climates, in fact any climate which differed from the one in which the physician resided.

I shall not, in contrast dwell upon the details of the contrasting situation which obtains in 1948. It is however the cost of subsidizing the vast number of auxiliary aids which we have brought to the aids of inspection, percussion, and auscultation which has pyramided the cost of medicine, and made it the important, socio-economic question of the twentieth century.

The vast amount of factual material which has accumulated in the past hundred years has in equal degree changed the practice of medicine. At the turn of the 16th century Francis Bacon, in the pride of his incomparable 19 year old mind, could say "I have taken all knowledge as my province." In 1848 a young graduate would have considered that the entire range of medical art and science was set before him. The century has brought changes indeed. There are now 15 boards in American medicine, each setting up standards which require many years of intensive study and training to meet. "General medicine" has itself become a specialty, and we of this association glow with pride when we think that our own beloved Buck Pressley is universally considered to be America's finest example of that most trying of all specialties.

Specialization has, perhaps, been necessary. But it has brought many complications. It is still proceeding. There is a distinguished alumnus of our college and an honorary member of the association who has for many years, in one of America's great clinics, confined himself to a study of the human retina, in health and disease. A colleague remarked that he wondered when Henry was going to announce that from now on he would confine his work to a study of the left retina alone. The two complicating factors of mounting cost and specialization have brought about striking changes in the form of medical practice.

In many parts of the world, Medical practice has been incorporated into state bureaucracy. The mode varies in accord with the social facade of the country. Since in temperament, traditions, and language, England is most nearly like us, we watch with particularly keen interest what is happening there. I am sure I do not have to remind you that under the Labor Government British medicine is undergoing socialization. To this socialization there is great resistance upon the part of organized British medicine. The British Medical Association, in organization, power and prestige, closely approximates our American Medical Association. It is significant that approximately 84% of British doctors voted, in a recent poll, and 90% of the votes were opposed to the government plan. This, in spite of the fact that the income levels under the bureaucratic plan were quite liberal. It is said that the organizers of the plan deliberately set the financial returns quite high in order to lure medicine into the fold. The fact that British medicine, almost to a man, was against the act, indicated that income was not the reason doctors do not wish to be regimented into a bureaucratic framework.

Rather, to paraphrase the editor of Collier's in a recent thoughtful paragraph, it is the sound conviction of all honest and experienced physicians that medicine in its double aspect as art and science, flourishes best in a free and democratic mode and that the doctor-patient relationship is a real and not sentimental factor which must have primary consideration.

Perhaps the most clinching argument in the whole matter is a modification of the old adage that "the proof of the pudding lies in the eating." Under the ideals inculcated during the past hundred years, American medicine has attained a position without parallel in the history of the world.

The experiences of the last two wars, in which a large proportion of American physicians took an active part, served to reinforce the feeling that socialization of medicine brought many evils. It can be said without fear of successful contradiction that where military medicine was good, it was because of the employment of the methods employed in our American civilian medicine, without administrative interference and red tape bungling. On the other hand, when Snafu and inefficiency was present, it could be clearly traced to that same bureaucratic rigidity which we regard with justified suspicion and contempt, and which certain contemplated laws would thrust on us now. No one wishes to return to the primordial situation of 1848, but the vast majority wish to avoid the strangling influence of regimented national socialistic medicine. A few years ago Dr. Bauer put the matter in words with which most of us find ourselves in agreement.

"We advocate continued expansion of the practice of medicine, with full development of approved voluntary hospital, medical, indemnity, industrial and commercial insurance against the cost of medical care; the development of public-health and diagnostic

facilities everywhere; the use of the voluntary insurance principle in caring for the medically indigent; the development of hospital facilities where present facilities are used to the utmost and are still inadequate; the use of federal funds to aid communities in public health measures, care of the indigent and construction of necessary hospitals when these communities are unable to finance the projects, but with retention of local administration. In a word let us move ahead steadily, but carefully, in a sound, evolutionary manner. We must not be stampeded into discarding and destroying what has given an unparalleled health record. Let us not forget that private enterprise has made America what it is."

There were many differences between the training, the conditions under which work was carried out, the technical tools, and the social-economics problems of those of us who are in meeting today, and these founding fathers of ours who in 1848 initiated the South Carolina Medical Association. But there were great similarities. Some of the problems are as old as time, and human nature changes little. It may be interesting to glance at some of the proceedings of that founding meeting. I quote from Dr. Waring's book.

"Monday, Feb. 14, 1948

"Pursuant to circulars issued by the Medical Society (this was the "Medical Society of S. C." founded in 1789 by 10 gentlemen practitioners of medicine in the city prior to the year 1783, who met at the residence of Dr. Peter Fayssoux and unanimously agreed to form a Medical Society), a large number of medical men, from all parts of the state, assembled at 10 o'clock this morning, at the Hall of the Apprentices Library Society.

On motion of Dr. Wragg, the meeting came to order and Dr. James Moultrie was called to the Chair, and Drs. Cain of Charleston and Johnson of Camden, appointed secretaries.

The following gentlemen as officers of the Convention were thereupon unanimously elected:

President

Dr. James Moultrie of Charleston

Vice Presidents

Dr. C. Ready — Edgefield

Dr. Isaac Branch — Abbeville

Secretaries

Dr. D. J. C. Cain — Charleston

Dr. R. Johnson — Camden

The convention then proceeded to pass upon certain resolutions, first resolving itself in a "State Medical Association." Many of these resolutions bring sharply into mind the kinship between ourselves and these doctors of a hundred years ago. I quote from a few:

"Resolved that in our transactions with apothecaries, we will deal exclusively with those who abstain from recommending and vending quack or patented medicine, whenever we have the option."

Here is one, which with a few changes might have

been passed this year, since it so closely simulates the activity of our association in State health matters.

"Be it resolved, that the Report on the Registration of Births, Marriages and Deaths, with an accompanying memorial, be presented to the Legislature of its next session, and Resolved that the members of this convention and the members of the Medical profession throughout the State be requested to explain to the Representatives and Senators in their districts, the importance of the measure and use their best exertions to obtain the passage of the bill."

It was moved that the President be requested to furnish the members of the Convention with certificates of membership to enable them to return on the railroad free of expense. Adopted.

The insistence on good and sound education which organized medicine has always maintained and its support of its colleges is strikingly exemplified in the following preamble and resolution offered by Dr. Dendy:

"However much other causes may tend to embarrass medical reform, we nevertheless regard the failure of Medical Colleges to require a strict conformity, even to their present low standard, as an impediment worthy of the most serious condition. And while it affords us much pleasure to know that the Medical College of South Carolina stands among the first, in her preparatory requirements and in the enforcement of them, we feel that more may yet be done to elevate her still higher.

"It is apparent to all of us that the term of lecturing in all our Medical Colleges is entirely too short to enable the different Professors to do that justice to their subjects which their importance demands, and that it is far too short to enable students profitably to receive the amount of instruction which should be contained in a course of lectures. The door of entrance also into Medical Colleges is not sufficiently guarded.

"The neglect on the part of first course medical students to attend regularly the lectures, is an evil of great magnitude. It is not only an obstacle to the attainment of Medical knowledge, but it tends to consequences far worse—the destruction of morals.

"The examinations for the degree of M. D. are not generally conducted with sufficient care to secure the ends contemplated by their institution. And as this Convention feels the greatest interest in the prosperity and usefulness of the Medical College of South Carolina, and as we look to her as the guardian of the Medical profession of this State, and as the institution which is to prepare those to whom are to be entrusted the progress and perpetuity of all reforms in the Medical profession, therefore

"Resolved, that this Convention does earnestly recommend, that the Medical College of South Carolina, lengthen the term of lecturing, from four to six months, that she may better guard the door of entrance and secure the attendance of first course

students by examinations; also that she should conduct her examinations for the degree of M. D. more rigidly.

"Resolved, that should she adopt the above recommendations, we will use our influence in her support."

The future is, for reasons foreign to the ideals and

hopes of medicine, uncertain. But if we maintain, in our lives and our endeavors, the courage and indomitable spirit of these forefathers, we may see the next one hundred years bring to fruition miracles only dimly visioned now. Let us salute them and seek to emulate their spirit.

Saddle Block Anesthesia In Obstetrics

Report Of 235 Consecutive Cases

ROWLAND F. ZEIGLER, JR., M. D., F.A.C.S.
Florence, S. C.

Pitkin and McCormack¹ published their paper on "Controllable Spinal Anesthesia in Obstetrics" in 1928. They described a form of low spinal anesthesia which was confined mainly to the perineal area, thus the term saddle block. The block, however, failed to gain widespread popularity at that time, because the anesthesia did not always remain localized in the originally intended spinal segments, but at times spread over a more extensive area. This difficulty has been eliminated by the addition of glucose to the anesthetic drug. Adriani and Roman-Vega² showed that the addition of glucose to the solution of drug, made the solution hyperbaric or heavier than spinal fluid. Apparently, the glucose also inhibits diffusion of the drug. Baker³ and his workers added small amounts of ephedrine or adrenalin to the glucose-drug solution, believing that this further increased and prolonged the localization of the mixture to the desired segments, by its vasoconstrictor effect on the arachnoid capillaries. Since the publication of Parmley and Adriani, "Saddle Block Anesthesia with Nupercaine in Obstetrics"⁴ in 1946, various types of low spinal anesthesia are being used increasingly in obstetrics with excellent results as to relief of pain, safety to mother and baby, and with a minimum of the heretofore feared side effects of spinal anesthesia in the obstetrical patient.

MATERIAL STUDIED

Since February 1947, saddle block anesthesia has been administered to 235 obstetrical patients at The McLeod Infirmary.

Primigravida	—126
Multigravida	—109
Youngest patient	— 15 years
Oldest patient	— 42 years (a grav. II with a 24 year interval between pregnancies).

All of the injections were personally supervised and administered by the author. The block was given routinely when the time element in the progress of labor allowed, and when there was no definite contraindication. It was not reserved for those patients known to have normal positions.

From the Department of Obstetrics, The McLeod Infirmary, Florence, S. C.

Presentation:

Vertex	—220
Occiput anterior	— 163
Persistent occiput posterior or transverse arrest	— 48
Breech	— 15
Transverse	— 1

Twins — 5 sets

Pre-eclampsia — 8

Diabetes Mellitus — 2

Premature babies (less than 4 lbs.) — 11

One patient had bilateral inguinal herniae

The block was not used merely for terminal anesthesia, but an attempt was made to relieve the latter part of the first stage of labor as well as the second, third and reparative stages. The injection was made when delivery was thought to be imminent within 2—2 1/2 hours. Analgesia in early labor was established when necessary by the use of barbiturates, or demerol and hyoscine.

TECHNIQUES AND MATERIALS

The technique and materials used were essentially those of Adriani and Parmley,⁴ as modified by the Baker³ group in New Orleans.

Materials:

Sterile gloves

Sterile pack

20 gauge lumbar puncture needle

5 cc. hypodermic syringe

2 cc. hypodermic syringe

21 gauge mixing needle

25 gauge hypodermic needle

Solutions

2 cc. ampoule of 1—200 sol. nupercaine (10 mg.)

3 cc. ampoule of 10 percent glucose

2 cc. ampoule ephedrine Hcl. 5% and procaine Hcl. 1%

The ampoules are kept in a jar under a solution of tr. merthiolate. The latter was chosen as the sterilizing agent because its color will penetrate a pin-point break in an ampoule that might otherwise escape attention. Nupercaine was chosen as the anesthetic drug, as it is longer-acting than other spinal agents, and can be used in much smaller

amounts, because of its potency. Cosgrove⁵ in 1930, used nupercaine for obstetrical anesthesia, but abandoned it because the extent of anesthesia was difficult to control and there were unsatisfactory results. The extent of anesthesia now can be safely controlled by making the nupercaine solution hyperbaric with glucose, and by carefully following a proven technique of administration.

Technique: Sterile gloves are put on, and the 5 cc. syringe is flushed first with 1 cc. of glucose solution, and then with 1 cc. of nupercaine solution. This is important because nupercaine in aqueous solution is precipitated in the form of an insoluble base by contact with the slightest amount of alkali. An alkaline residue may remain in the syringes from sterilization methods. $\frac{1}{2}$ –1 cc. 2.5–5mg) of nupercaine is then drawn into the syringe, followed by 1 cc. of glucose, and 0.4 cc. of the ephedrine-procaine solution, and they are mixed. 1 cc. of procaine solution is drawn into the 2 cc. syringe for the skin wheal. Lumbar puncture is performed with the patient in the sitting position. This is simplified if the patient sits near the edge of the table or bed, with her feet on a stool in front of her, her arms across her chest, and her head flexed on her chest. An assistant sterilizes the puncture site, then stands directly in front of her with his hands supporting the patient's shoulders. She is encouraged to lean forward slightly and "bow" her back out. The fourth or third lumbar interspace is used for the puncture.

No technical difficulties were encountered in this series. In one case there had been a previous spinal fusion, but the second interspace was entered, and satisfactory saddle anesthesia resulted. As little spinal fluid is wasted as possible, and the solution is rapidly injected into the subarachnoid space without mixing spinal fluid in the syringe. Care is taken not to inject the solution during a pain, however, because of the increased intrathecal pressure during a uterine contraction. After injection, the needle is quickly withdrawn and the patient is made to sit up straight for 90 seconds, by the clock, if 5 mg. of nupercaine was used. (If only 2.5 mg. of nupercaine was given, the patient need remain sitting up only 30 seconds, or if 4 mg. of nupercaine was given she is kept sitting up for 60 seconds. In most of these cases, the 5 mg. dose was used. Smaller doses were used for the patients with short spines, or in those in whom a long anesthesia was not necessary, because of the proximity of delivery). If a contraction is occurring at the end of the 90 seconds, or otherwise calculated time, the patient is kept sitting until its termination. She is then placed in the recumbent position with her head cocked up on a pillow. Distribution and level of anesthesia may be altered by varying the time in the sitting position. Usually within a minute the patient notices a pleasant flushing warm sensation, and in two to five minutes experiences complete relief from pains. It is rare for her to sense more than 2 pains after the injection, and the change in facial expression from one of pain, fear

and strain and apprehension, to one of pleasant relaxation is dramatic. Many patients who have had prolonged and exhausting labors, fall into a natural sleep, and a few have actually slept through the delivery. Six or eight minutes after injection, the skin of the abdomen is tested with pin pricks to determine the level of anesthesia. A definite change in perceptibility from dull to sharp should be noted not higher than the level of the tenth dorsal, the level of the umbilicus. All sensory fibers from the uterine are derived below this level and the motor fibers apparently above. The degree of anesthesia decreases as one ascends the cord. "The sensory and autonomic fibers of a mixed nerve are more sensitive to a local anesthetic drug than the motor,"⁴ thus by having the greatest concentration of the drug in the sacral and lumbar areas, there is no diminution in the number of contractions. Neither are the recti muscles affected appreciably, and the patient can bear down if requested. During the first 10 or 15 minutes after injection the height of anesthesia may be altered slightly if necessary by postural changes. After the anesthesia has "set" for 15 minutes, its level is not altered by placing the patient in lithotomy position.

RESULTS

Method of delivery:

Low (outlet) forceps	—162
Mid-low forceps	— 48
Breech extraction	— 26
Ritgen's maneuver	— 4

Management of persistent occiput posteriors and transverse arrests:

Scanzoni maneuver	— 28
Podalic version	— 7
Delivered as posterior	— 12
Manual rotation	— 1

In one twin case the second twin was delivered by breech extraction after a podalic version, without the addition of supplementary anesthesia. Two other podalic versions (high transverse arrests) were done without additional anesthesia. These versions were done between uterine contractions.

Perineal repairs:

Episiotomy	—124
1 degree laceration	— 41
2 degree laceration	— 8
3 degree laceration	— 2
Elective perineorrhaphy	— 3
Additional (terminal) anesthesia—	19
Ether	— 13
Ethyl chloride inhalation	— 6
Reason for additional (terminal) anesthesia:	
Elective (for podalic version)—	7
Pain	— 12

There was only one complete failure of anesthesia in the series. This occurred in a primigravida who was given a repeat injection 15 minutes after the initial one, as there was no evidence of any anesthesia.

Particular care was taken to prevent a technical error with the second block, and a free interchange of spinal fluid into the syringe was noted before injecting. Again, however no relief of pain was afforded and only a few transient areas of paresthesia in the legs were noted. It was assumed that she therefore was not susceptible to mupercaine, and she was eventually delivered under ether anesthesia.

Of the remaining eleven cases who actually needed additional anesthesia at the time of delivery for reason of pain, six were difficult midforceps deliveries of large babies, three of which were persistent occiput posterior positions requiring Scanzoni maneuvers.

Repeat saddle blocks during the same labor were done 5 times, all in primigravidas. One repeat was in the above mentioned failure, another was successfully repeated in 15 minutes, and the others were done because of return of sensation of uterine contractions before time of delivery. The shortest interval between repeat blocks was one hour and fifty minutes, and the longest, three hours, fifteen minutes. The patients receiving a second block were completely relieved again and proceeded uneventfully through delivery. The longest interval between administration of saddle block and delivery was four hours, forty-five minutes, and this delivery was completely painless.

There were no precipitate, spontaneous deliveries under the saddle block, though this might occasionally occur in a very relaxed multipara. It practically never occurs in the primigravida; the presenting part will conveniently wait on the perineum for the accoucheur, and thus will spare the delivery room personnel the excitement and frenzied rush usually attendant with the appearance of a bulging perineum.

Small doses of pitocin were occasionally used in the second stage of labor with no untoward effects. When used, the pitocin injections were made on the inner thigh surface, and were therefore painless.

Two retained placentas occurred, and were manually removed painlessly without additional anesthesia.

Episiorrhaphies and repair of lacerations were completely painless in all cases. One cervical laceration occurred and was repaired. Perineal anesthesia lasts far beyond relief of uterine pain because of the concentration of the anesthesia solution in the conus sac.

SUMMARY OF RESULTS

Satisfactory relief from pain of labor with saddle block anesthesia alone was attained in 234 cases up to time of delivery, and 216 cases through actual delivery. There was one complete failure of anesthesia, and terminal anesthesia was necessitated at the time of delivery because of pain in 11 other cases. In 7 cases, elective terminal general anesthesia was administered to facilitate podalic version.

MORBIDITY

There were no maternal deaths in the series, and there were no incidences of "spinal shock," drug allergy, or postpartal or meningeal infection. There was no evidence of uterine atony or hemorrhage, and the impression was received that postpartal bleeding was perhaps less than with general anesthetics. One patient had excessive vaginal bleeding on the 8th postpartal day and a retained placental fragment was curetted from the uterus. All patients were allowed early ambulation, and there were no incidences of nerve or back injury. Severe post-spinal headaches occurred twice and lasted from the third to the fourth day.

There were 4 fetal deaths in the series:

- (1) Erythroblastosis fetalis — expired 3 days.
- (2) Probable cerebral hemorrhage — expired 3 days.
(Pre-eclamptic primigravida with prolonged labor and persistent high occiput posterior position; version delivery).
- (3) & (4) Premature twins — expired 8 hours; & 5 days. (Each twin weighed less than 3 lbs.)

DISADVANTAGES

Nausea and vomiting shortly after the administration of the anesthesia was the most unpleasant feature in many cases, early in the series. This occurred most frequently when the stomach was not empty. As this series progressed the incidence of nausea or vomiting was decreased as patients were allowed nothing by mouth after labor was established.

At times labor is slowed, especially in the second stage, because of the absence of bearing down stimulus, and there may be loss of station at times, when the presenting part is not well engaged. The incidence of operative deliveries is therefore increased. In the second stage of labor, however, considerable expulsive force can be exerted by the patient, if she is told when she is having a contraction and is instructed to go through the motion of straining down.

Persistent occiput posterior position, or rather failure of rotation, apparently occurs more frequently under saddle anesthesia because of the complete relaxation of the pelvic musculature.

Postpartal urinary retention may be slightly more common, however more than the catheterization is seldom necessary.

Postpartal headaches occasionally occur and do not respond to ephedrine, gynergen, benzedrine, or the usual mild anodynes. They are usually relieved by lying flat in bed. No headaches occurred in the last 150 cases of the series, (after the routine use of a tight abdominal binder 12 hours postpartum was employed). This was suggested by Weintraub⁶ et al, who showed that "the two factors responsible for the headache are: first, and more important, the sudden release of intra-abdominal pressure following delivery, superimposed on the action of the anesthetic; and second,

spinal fluid leakage." A pooling of blood in the splanchnics results from the sudden release of intra-abdominal pressure augmented by the vasomotor paralysis resulting from the anesthetic drug action on the sympathetic nerves. Weintraub⁶ demonstrated that dramatic relief from post-spinal headache is afforded by a simple tight abdominal binder, although almost 50 per cent of the patients may show no evidence of orthostatic hypotension and/or tachycardia.

Spinal shock is a potential hazard, but is apparently rare because of the small amount of drug used and its localization chiefly to the caudal area.

CONTRAINDICATIONS

(suggested by Schmitz and Baba (7))

- (1) Obstetrical complications such as disproportion, placenta praevia, abruptio placenta, etc.
- (2) Poor general condition, such as shock, coma, hypotension, or sepsis.
- (3) Diseases of the spine, cerebrospinal system, or skin at the site of puncture.
- (4) Drug hypersensitivity.
- (5) Unfavorable patients, such as those with chronic backache or headache, or those desiring to be asleep.

PRECAUTIONS

Strict attention must be paid to details of technique, solutions must be pure, and the apparatus must be scrupulously clean. No injection should be made when the puncture needle yields a bloody tap, because of the high toxicity of nupercaine, even in small amounts, if introduced accidentally into the blood stream. If the puncture needle causes radiating pain, no injection should be made because of the danger of cord or nerve injury. Schmitz and Baba⁷ recently reported one case of foot drop resulting from a low spinal anesthesia. Oxygen, ephedrine, and adrenalin should always be kept on hand in case of fetal anoxemia and bradycardia caused by sudden maternal hypotension.⁷

CONCLUSIONS

Though this series is small, it illustrates the practicability of the use of saddle block anesthesia in obstetrics in the smaller general hospital without benefit of a department of medical anesthetists. The results

obtained suggest conclusions in accord with those of much larger series recently reported.^{7, 8, 9}

A high incidence of outlet forceps deliveries prevails. This is common to most regional anesthetic methods.

The favorable effect on the baby, plus the minimal trauma to the birth canal which can be achieved when such a high degree of perineal relaxation is attained, suggests that this type anesthesia for certain operative deliveries from below has many advantages over inhalation agents.⁹

Rapid relief of the discomfort of labor and delivery is effected in more than 90 per cent of cases, with maximum safety to mother and baby, and particularly, the premature baby.

Technique is not complicated, a minimum of paraphernalia is required, and nursing care is simplified.

The method is satisfactory to patient and relatives, as well as obstetrician and nurses.

It seems apparent that since the advantages are many and the disadvantages few, low spinal anesthesia at present, is the one of choice in obstetrics.

REFERENCES

1. Pitkin, G. P. and McCormack, F. C.: Surg., Gynec. & Obst. 47: 713-726, 1928.
2. Adriani, J., and Roman-Vega, D.: Am. J. Surg. 71: 12-18, 1946.
3. Baker, W., et al.: Personal Observations & Communications, 1946.
4. Parmley, R., and Adriani, J.: South M. J. 39: 191-195, 1946.
5. Cosgrove, S. A.: Am. J. Obst. & Gynec. 22: 763-767, 1930.
6. Weintraub, F., Antine, W., and Raphael, A. J.: Am. J. Obst. & Gynec. 54: 682-686, 1947.
7. Schmitz, H. E., and Baba, G.: Am. J. Obst. & Gynec. 54: 838-847, 1947.
8. Weaver, R. T., Adamson, D. L., and Johnson, T. L.: Am. J. Obst. & Gynec. 51: 766-770, 1946.
9. Haugen, J. A., and Benson, R. C.: Am. J. Obst. & Gynec. 53: 805-811, 1947.

The Technic Of Saddle Block Analgesia In Obstetrics

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In searching for yet another method to relieve the pains of childbirth, many obstetricians have tried the method of "saddle block" analgesia¹ during labor and delivery.

The term "saddle block" is a descriptive one defining the area of the lower abdomen, perineum, and thighs affected by the subarachnoid injection of the drug used. The result of the spinal injection is analgesic rather than anesthetic in that it relieves pain without loss of consciousness.

The data to be mentioned are derived from the experience of following some 1000 cases personally or under supervision while on the obstetrical service of The University of Tennessee and the John Gaston Hospital, Memphis, and other hospitals. These cases were done over the period of January 1, 1947 through April 1, 1948, and do not necessarily reflect the opinions of others but merely emphasize personal experience in these cases.

It is manifestly difficult to ascertain which of the preanesthetic drugs is best for the patient in active labor. After being assured that a low spinal injection (often used synonymously with "saddle block" analgesia) is desired by the patient and that she is in active labor as determined by progressive uterine contractions and dilatation and effacement of the cervix, seconal grains 1-1/2 or nembutal (pentobarbital sodium) grains 1-1/2, or sodium amytal grains 1-7/8 to grains 3 may be given orally, the latter drug being preferred in the hypertensive patient as it tends to lower the blood pressure. The barbiturates are used as an amnesic drug—are not analgesic, and cannot be depended upon to produce sedation or sleep in the presence of pain.² Analgesic drugs as morphine grains 1/6 or demerol milligrams 100 may be given in conjunction with the amnesic drug scopolamine or hyoscine grains 1/150 once the patient is in active labor and at the discretion of the physician. Respiratory depressant drugs are withheld in the event of fetal immaturity.

The primigravid patient is usually given the "saddle block" injection when the head is engaged and the cervix fully effaced and dilated 8 cm. The multigravid patient is given the subarachnoid tap when the cervix is less dilated, usually 6 to 7 cm., the choice of time

necessarily depending upon the position and station of the fetal head, the state of the membranes, and the progress of labor.

Method

The patient is supported in a sitting position with the legs over the edge of the bed and with her back exposed to the operator. The patient is never allowed to sit up if the perineum is bulging for fear of damage to the fetal head. With position for a spinal tap assumed, the operator using sterile gloves and face mask, washes a large area of the back with alcohol and then tincture of merthiolate or any other accepted antiseptic agent. He identifies the L-4 interspace, and using a 22 gauge needle quickly pierces the skin and slowly penetrates the fascia, then enters the subarachnoid space. We think preliminary infiltration of the skin prior to the spinal tap is only an added and useless painful stimulus. Unless under increased pressure, the spinal fluid will drip from the needle slowly. The syringe containing the drug to be used is connected to the spinal needle and, being assured that a uterine contraction is not present, the injection is made rapidly, taking about 2 to 3 seconds. However, before the injection is made, it is necessary to aspirate just enough spinal fluid to make sure one is still in the subarachnoid space. Barbotage is never practiced. The needle is removed slowly, allowing the tissues to close in around the puncture site and lessen chances of loss of spinal fluid. Immediately at the end of the injection the patient is timed in the sitting position for 30 seconds, then allowed quickly to assume the recumbent position with head on a pillow and anteflexed. The patient is encouraged to remain as quiet as possible, and the blood pressure is immediately taken since the most alarming hypotension usually occurs early. Ephedrine grains 3/8 may be given intravenously slowly (3 minutes) in case hypotension causes sweating, pallor, extreme nausea, or fetal heart tones lower than 90 per minute. Since many of the blood pressure falls are not severe and are only transient, it is best not to rush into the hurried use of vasopressor drugs. First, the patient should breathe oxygen. Simple elevation of both lower extremities to a 70 to 90 degree angle with the recumbent body often quickly corrects a transient hypotension. It is, however, imperative that one have oxygen, ephedrine, methedrine, and coramine quickly available.

Although five different drugs were used in the present series, only two will be mentioned for the

(Author—Dr. Bryan is a graduate of The Medical College of South Carolina (1944), and is now engaged in special study in gynecology and obstetrics at The University of Tennessee).

sake of simplicity—"Heavy" Nupercaine (Ciba) and Metycaine 1.5 per cent solution (Lilly). Both drugs are made hyperbaric by the addition of dextrose, thus making the solution heavier than spinal fluid so that, with the patient in the upright position, it gravitates to the lower level of the spinal canal, giving the saddle block analgesic effect. The drugs are prepared premixed in a small vial and need only withdrawal and injection of the proper amount, 1 cc. in case of Nupercaine, 2 cc. in case of Metycaine. The addition of two-tenths ($\frac{2}{10}$) of a cc. of 1:1000 adrenalin to the solution is said to enhance the duration of effective analgesia.

After injection the level of skin analgesia is tested with the patient lying in bed. If the proper technic described above is used with the patient lying on a flat non-sagging bed, the level will, in the greater percentage of cases, assume a skin analgesic level compatible with dermatone T-10 at the level of the umbilicus. Higher levels infer improper technic such as (1) spinal injection at L-3 or above, (2) permitting the patient to lie down in less than 30 seconds, thus allowing the hyperbaric solution to ascend the spinal canal to a too high level or (3) injecting the solution during a uterine contraction causing spinal fluid turbulence that forces the drug to higher than desired levels in the spinal canal.

It is, of course, assumed that the physician practicing "saddle block" technic has a more than conversant knowledge of spinal injections and its hazards, that he practices rigid aseptic technic, that he remains in constant attendance for at least one-half hour until a time at which the blood pressure has stabilized, and there are no subjective signs of distress or objective findings of lowered or irregular fetal heart tones.

The absolute contraindications to spinal analgesia are: diseases of the central nervous system; moribund patients; blood stream infections; pernicious anemia with cord symptoms; arthritis, spondylitis and other diseases of the spinal column; pyogenic infection of the skin at or adjacent to the site of the lumbar tap.

Relative contraindications are hysteria or excessive nervous tension—both conditions which presuppose more than usual care in the selection of the proper preanesthetic medication. Other relative contraindications to spinal puncture are: chronic backache; sensitivity to drugs; the possibility of severe hemorrhage during operation; hypotension (in cases not due to Addison's disease or associated with shock, this has become of relatively little importance because of the effectiveness of ephedrine in restoring the blood pressure to normal). Hemorrhagic spinal fluid is another contraindication to intraspinal injection unless the operator can enter another interspace and receive clear spinal fluid. Spinal injections should not be done in the face of cardiac decompensation or massive pleural effusion.

Impressions Gained from the Use of the "Saddle Block" Technic

1. Simplicity of method of "saddle block" technic if all contraindications are strictly adhered to.
2. Usefulness in cases of upper respiratory infections where inhalation anesthesia would be dangerous.
3. The mean duration of complete analgesia from uterine contraction pain will average 2 hours. Perineal analgesia is longer by 1 to 2 hours.
4. A moderate increase of occiput posterior and occiput transverse positions may be expected.
5. A questionable increase in the duration of the second stage of labor may be expected.
6. It must be emphasized that in breech presentation there is extreme relaxation of the lower uterine segment and birth canal in "saddle block" analgesia, and care must be exercised in working between uterine contractions and to avoid vigorous manipulation of the active upper segment of the uterus.
7. It was determined that the best method of handling the second and third stages of labor was delivery of the baby slowly after the method of Dieckmann³ then the injection of ergotrate 0.2 milligrams or 0.4 milligram is given intravenously after the placenta has been inspected and found complete.
8. One may expect a third stage blood loss of less than 100 cc. in 70 per cent of cases.
9. Of greatest importance is the fact that 95 per cent of babies delivered under "saddle block" technic will breathe spontaneously in less than one minute following delivery. In the premature infant this early spontaneous breathing is of extreme value.
10. One may expect no blood pressure changes in one-third of the patients; a maximum fall greater than 20 millimeters of mercury in 26 per cent of cases; seventy per cent of the total cases require no treatment for the fall in blood pressure.
11. Only the first postpartum catheterization incidence is increased in the "saddle block" patient as compared with a control group having inhalation anesthesia.
12. Postpartum headaches may be expected in 15 per cent of cases. Besides the usually accepted treatment a tight abdominal binder may be employed after the method described by Weintraub.⁵
13. Approximately 80 per cent of patients registered enthusiasm for the technic.

Summary

1. A discussion of the technic of "saddle block" analgesia in over 1000 cases has been presented along with certain impressions gained from the method.

2. Freedom from painful uterine contractions may be expected to last over two hours.
3. Best application of the technic is for the premature infant.
4. The patients' reaction to the technic was, for the most part, enthusiastic.

I would like to express thanks to Dr. Frank E. Whitacre, Professor and Head of the Department of Obstetrics and Gynecology of The University of Tennessee College of Medicine and of the John Gaston Hospital, Memphis, for reviewing this report and allowing me to use material in his department.

BIBLIOGRAPHY

1. Parnley, R. T., Adriani, John: *Am. J. Obst. & Gynec.* 52: 636-640, 1946.
2. Goodman and Gilman: *The Pharmacologic Basis of Therapeutics*, New York City, Macmillan Company, 1941, p. 131.
3. Dieckmann, W. J., et al: *Am J. Obst. & Gynec.* 54: 415-427, 1947.
4. Weintraub, F., et al: *Am. J. Obst. & Gynec.* 54: 682-686, 1947.

The Use Of Pentothal As A General Anesthetic In Vaginal Delivery

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Many agents have been used for terminal analgesia and anesthesia for vaginal deliveries in the past. Ether, chloroform, G. O. E., spinal and caudal anesthesia, have all been used with their various advantages and disadvantages. I have recently used pentothal as a general anesthetic for vaginal delivery in about twenty cases. I chose pentothal because of its following qualities:

1. Ease of preparation and administration
2. Rapidity and pleasantness of induction
3. Lack of effect on uterine musculature
4. Safety to mother and baby

1. Ease of preparation and administration—The preparation of pentothal for intravenous anesthesia is certainly simple. We keep a sterile tray in the delivery room at all times so that the anesthetic can be fixed there. The tray contains two (2) 20 cc. syringes, two (2) 20 gauge needles (one long and one short), and one (1) small bowl. The solution is prepared by dissolving one gram of pentothal in forty (40) cc. of sterile distilled water, making a two and one-half (2-1/2) per cent solution. This solution is administered intravenously by either a physician or nurse. We usually give six (6) to ten (10) cc. of a two and one-half (2-1/2) per cent solution as the first dose and follow this with two (2) to three (3) cc. at a time until adequate anesthesia is obtained. The anesthetic is started at the time the cervix is fully dilated. Oxygen is given to the mother routinely. The average case in this series received about three quarters of a gram of pentothal. This was adequate in all cases to repair an episiotomy if one had been done.

2. Rapidity and pleasantness of induction—The induction with pentothal is exceedingly rapid. The patient is asleep from one to two minutes after the vein has been pierced. We have all had the rather undesirable experience of having a patient fully draped for delivery and then have to pass through the excitement stage of an ether anesthesia. There is, of course,

little sterility left after such an episode. The pleasantness of the anesthetic is another very definite advantage. The sensation of choking and being smothered to death are entirely absent.

3. Lack of effect on uterine musculature—It is well known that the barbiturates do not have an inhibiting effect on uterine musculature if given in small doses. Many investigators and clinicians use nembutal intravenously for the control of pain during the first stage of labor. If a small amount of pentothal is given and the depth of anesthesia remains light, the patient may go on to a spontaneous delivery. If a deeper anesthesia is given and a forceps delivery done, the third stage is not slowed as it is with many of the inhalation anesthetics.

4. Safety to mother and baby—Pentothal has been used in approximately twenty cases and there has been no case of marked respiratory depression or of any anesthetic crisis of any kind. In this series, induction has been smooth, and the duration of anesthesia has been short. As mentioned above, oxygen is usually administered to the mother. The babies have all been a bit cyanotic but have all breathed spontaneously. I do not believe the degree of cyanosis has been any greater with pentothal than with ether. We have routinely used demerol, hyoscine and nembutal during the first stage of labor for control of pain. As we all know, this combination of drugs usually gives a cyanotic baby.

In the cases in which pentothal has been used, all but two were multipara. Three-fourths of the multipara were delivered with low forceps and one-half had episiotomies. There was no postpartum hemorrhage or lung complication.

Summary: Eighteen (18) patients were delivered under pentothal anesthesia. The results were satisfactory.

We believe there are many advantages to be found in the use of this drug in vaginal deliveries.

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THE FIGHT IS ON

During the recent political campaign, President Truman presented a Health Program prepared for him by Mr. Oscar Ewing. Physicians who read this proposal tended to smile somewhat indulgently as they thought to themselves, "Well, it's the same old story of compulsory health insurance. Thank heavens we will stop hearing about that for a while when we get a Republican administration in Washington."

Came November 2—and Mr. Truman is in the White House for another four years. Now what are these same physicians saying? If they are talking at all, this is what you will hear, "For years we have been skirmishing around with the proposal for a system of federal medicine, and we have been able to win most of the skirmishes. But now the big fight is on. Each side is marshalling its forces and preparing for a battle to the finish."

There is no doubt that the big fight is on—and what the outcome will be no one can tell with any certainty at this moment. Each side has its strength and its weaknesses and each is mapping its strategy with skill and caution. Each opponent is claiming the eventual victory, yet neither one is underestimating the strength of the other.

It is the type of battle which can only take place in a Democratic nation where the final decision will be made by the people themselves, expressed through their chosen representatives in the Congress.

TWENTY-FIVE DOLLARS

At the last meeting of the House of Delegates of the American Medical Association, it was decided to assess each member of the Association twenty-five dollars. Our Council, in session recently, heartily endorsed this assessment and urged that every member of our Association pay this assessment immediately. It should be paid to the county society treasurer who will in turn send it into the state treasurer for remittance to the A. M. A.

We would like to present our reasons for believing that each member of our Association should not only feel that it is an obligation but also a privilege to

send this amount of money to the American Medical Association, where it will be to educate the people of this country in the field of medical affairs.

The American Medical Association is the only national organization which can speak authoritatively for the physicians of this country.

Through its hundred years of existence the American Medical Association has never leveled an assessment upon its membership. What other large organization can say the same. Labor unions, trade organizations, fraternal bodies—all have their dues or assessments. It is high time that the membership of our national medical organization secure financial support from its members.

The American Medical Association can carry on a campaign of education on a national level which will reach to the farthest corner of every state—and every state will profit thereby. Through the radio, magazines, the daily press, the message of a free medicine as opposed to state medicine can be preached for all to hear—if sufficient funds are available for the purpose.

The people of this country must be shown that physicians may disagree upon a multitude of subjects but that they are united in their fight against any compulsory socialistic form of medical care as proposed by Messrs Murray, Ewing, Altmeyer, and others. This can best be accomplished through united support, financial and otherwise, of the American Medical Association.

Every physician has too much at stake to turn down any opportunity toward winning the fight against political medicine. On the one hand is a free practice built up over a period of years and through the expenditure of thousands of dollars—on the other hand is \$25.00. The odds are better than a thousand to one, and there is at least an even chance to win. What man could turn down such a sporting proposition, even if he had no other reason for sending in his twenty five dollars.

Yes, we feel that every member of this Association should not only be willing but should be anxious to send in his \$25.00.

PUBLIC RELATIONS

No phrase has come to the fore more quickly in recent years than the phrase, "public relations." And we have often wondered what was meant by those who bandied the expression so freely in their speech.

Since we had a part in establishing a Department of Public Relations in our Association, it would not be amiss for us to give our ideas upon the subject.

Public relations, it seems to us is composed of three parts: (1) Making adequate plans for doing the job that has to be done, (2) Doing it efficiently and well, (3) Doing it in such a way that it will command commendation and respect.

Perhaps we can make ourselves a bit clearer through a simple story.

Four men were employed to mow a man's yard, each to come on a different day.

The first man came at breakfast time but found there was no lawnmower on the premises, and had to go back after his own. By the time he returned, it was too late for him to finish the task before dark. (Poor public relations—inadequate planning).

The second man arrived with his lawnmower, rushed through the job, left the fringes around the flowerbeds uncut. (Poor public relations—inefficient work).

The third man came at daybreak, before the owner and his family had awakened. His workmanship was excellent, but the sound of the lawnmower disturbed all of those in the house. (Poor public relations—a task executed efficiently, but done in a manner to irritate others).

The fourth man arrived at a reasonable hour, did his work well, and left before dark. (Good public relations—he was given the job permanently).

HOW ARE OUR PUBLIC RELATIONS?

It has become trite in many circles to say that the public relations of the medical profession is at a low ebb. Is this true?

Let us consider, in the light of the definition which has been given above, the situation as we see it on the national, state, local, and individual levels.

National level

(1) "Making adequate plans for doing the job that has to be done." The medical profession, through its own organization, the American Medical Association, has done a splendid work in the scientific field—this is acknowledged by all. Perhaps it has been a bit slow in advancing its ideas in the broader field of social welfare, but in recent years it has come forth with a definite program. This program is somewhat less aggressive and specific than the more forward looking would advocate, but it is basically sound. It is a great advance from the position held ten years ago, but still carries the conservatism which a physician adopts when he is confronted with some new procedure in his own practice.

(2) "Doing it efficiently and well." For any non-governmental organization to carry on a nation-wide program is a herculean task—particularly when that program affects such important factors as physical welfare and human life. It requires effort and expense on a large scale. With the tools with which it has had to work, we feel that the American Medical Association has done a good job. But we also feel that more effort and more money must be thrown into the work before we can say that all is being done that should be done.

(3) "Doing the job in such a way that it will command commendation and respect." The American Medical Association, reflecting the makeup of its individual members, is an individualist—and because of this has antagonized a good portion of the public. There has been a tendency in the past for the American Medical Association, like the individual physician, to feel that affairs of medicine were its prerogative and that no plans for medical care should be promulgated without first seeking its advice and assent. The American Medical Association, like the individual physician, has tended to wait until the patient comes in for consultation rather than to thrust his advice upon someone who has not asked for it. The American Medical Association, again like the individual physician, has appeared to be content to let its own works speak for themselves without making any effort to educate the public as to what has been done and is being done. But, in recent years, the attitude has changed. Coming down from its slight pedestal, it is now meeting other groups and organizations around the conference table. It is making its ideas and thoughts known in legislative halls before they are sought by the legislators. And an aggressive educational program is being undertaken through which the public will be appraised of the work which the Association has done and is doing for the public good.

State level

(1) "Making adequate plans for doing the job that has to be done." Through the years the South Carolina Medical Association attempted to carry on its work in a rather disjointed and disorganized fashion. That much good was done cannot be gainsaid, but there was a lack of definite purpose. Four years ago, the Association adopted a broad, long-range program—the Ten Point Program—in which was outlined the problems which presented themselves in this state and the methods through which this should be accomplished. Although only four years of age, this Program needs to be brought up to date—and efforts along this line are being made.

(2) "Doing the job efficiently and well." Some parts of the Program have been stressed and results accomplished, as evidenced by the fact that since the Program was adopted in September, 1944, the following objectives have been achieved (in cooperation with other groups and organizations); A Blue Cross (Hospital Service) Plan is now operating on a state-wide

basis, a State Health Council has been organized, a state-wide survey of hospitals has been made and a carefully integrated program for hospital building and expansion adopted, a much needed expansion of the Medical College in Charleston is under way, scholarships for worthy boys have been provided at the Medical College, clinics (in which individual members of the Association are extremely active) are now being carried on in the fields of cancer, syphilis, well babies, etc. There are other parts of the Program, however, which have not been stressed and these need to be dealt with—a Medical Service Plan must be put into effect, more people must be protected against the expense of sickness through the Blue Cross and commercial insurance, better care must be provided for the indigent, the public must be better educated as to what the Association has done and is doing for their welfare.

(3) "Doing the job in such a way that it will command commendation and respect." The observations made of the American Medical Association in this connection might well be made of our own Association, although being a smaller organization we believe that we have been able to move faster in the line of change than has the mother organization. Though our Association has attempted to convince the public that our Program is geared to the best interests of the public, there is still a feeling on the part of many that doctors are still for doctors first. It is our belief, however, that our Association is respected more today for what it is trying to do than it was ten years ago. But there is still much to be done in the line of educating the public as to our true motives.

Local levels

It is our belief that we are extremely weak in our public relations at the local level. By local level we mean the level of the county, community, or individual hospital. And the reason for this is obvious—there is little if any definite plan of action provided by the local group. How many county societies have studied the specific problems of their own county in the field of medical care and have made specific plans for handling these problems? How many times have the physicians in a given community gathered together to determine the medical needs of that particular community? How often will the staff of a given hospital leave the realm of the scientific and make a determined study of its own public relations? Until steps are made for the local group to map out its own program, it is impossible to appraise the public relations on the local level.

Individual level

It has been said, and we believe rightly, that the course of medical care in this country will be determined by the public relations of the individual physician. Or to put it somewhat differently, the type of medical care which this country will adopt will be the type which the individual voter believes to be the

one best suited to his own particular needs. Whether he will vote for a federal compulsory system of medicine will depend upon his satisfaction or dissatisfaction with the medical care which he is now receiving, as contrasted with the type which he thinks he will receive under the new dispensation.

Let us discuss the public relations of the individual in the terms of our definition:

(1) "Making adequate plans for doing the job that has to be done." Most physicians are trained scientifically for the work which they are doing, but there are those—and their number is not great but unfortunately their publicity is—who attempt medical and surgical procedures for which they are not prepared. Such men would do well to limit their work to the fields in which they have had training or else to seek further education. But the physician is more than a man of science, he is also a citizen and is so judged by those who know him. How much does John Smith, M. D. concern himself with the affairs of his community and what type of leadership is he offering in those phases of community life which bear directly or indirectly on the physical welfare of the people? What is he doing about the welfare of the school children, about the physical and health education of the boys and girls? What leadership has he given in making plans for better medical care of the indigent? How well does he support the work of the health department? How much interest does he take in the promotion of a Health Council and of its activities? What effort is he making to see that more people are making provision for prepayment of medical and hospital service? These and many other questions could be asked of himself by every physician as he attempts to appraise his own standing in the field of public relations.

(2) "Doing his job efficiently and well." Here again, the physician might ask himself some questions. Am I doing as good a job scientifically as I am trained to do? Do I examine my patients thoroughly? Am I keeping up with the newer things in medicine through study, attendance upon medical meetings, refresher courses? Am I assuming the place of leadership in my community in those matters which deal with health? Do I feel it my personal responsibility to work for better health conditions and medical care for the people of my town or city, and am I making strenuous effort to fulfill that responsibility? What is the basic urge of my work—to make money or to be of service? Am I charging a reasonable fee for my work or am I trying to make hay while the sun shines?

(3) "Doing the job in such a way that it will command commendation and respect." It is in this particular phase of public relations that the average physician will be largely appraised by his patients and by the people in his community. Is John Smith, M. D. satisfying the medical needs of those who call upon him—that is the question which the average citizen is asking.

It appears to us that the amount of criticism against individual physicians is growing. Whether this is a natural part of our present social turmoil or whether it is a well conceived and executed sneer campaign directed against physicians by some particular group or organization, we cannot say. But it behooves the physician to be alert to the situation and to see that his actions directly refute any such criticisms.

By and large, as we have seen him, the average physician is not only satisfying his patients but is a respected leader in his community. But there are those, and their number is not too few, who are conducting themselves in such a manner as to provoke ill-feeling toward the profession in general. The physician who keeps patients waiting for long periods of time in his office, the physician who insists upon seeing even the acutely ill patient at his and not the patient's convenience, the physician who refuses to pay calls or to see sick patients at the office or hospital after his regular office hours, the physician who charges fees entirely out of line with the patient's ability to pay, the physician who refuses to care for a patient until the financial arrangements have been made, the physician who not only makes good money but who allows himself or his wife to make a display of his affluence for all to see, the physician who feels no responsibility on his part to make sizeable contributions to charitable and philanthropic enterprises in the community, the physician who refuses to take any part in community activities which deal with matters aimed toward the improvement of the health and welfare of the people, the physician who is so completely satisfied with his own little circumscribed field of activity that he is blind to the socialistic trends which are sweeping the entire world today—these are the men who are displaying the poorest of public relations and are bringing discredit to the entire profession.

Perhaps a story—and a true one—will show the difference between good and poor public relations on the individual level, better than a thousand words.

A little baby became acutely ill one evening, developing a temperature of 104. The family physician, the only physician in the small community, was called—and he lived just two blocks away. The physician explained that he could not come at the moment, he was getting ready to go with a group of friends to a basketball game in a neighboring town. He told the parents that he would come around when he returned and suggested giving the baby some aspirin in the meantime. The aspirin was given but the baby continued to be restless and feverish. Finally the parents wrapped the baby in a blanket, drove twenty miles to another town and called a second physician. The latter individual got up out of bed, examined the baby, made provisions for appropriate treatment, and satisfied the parents.

Let him who will determine for himself what constitutes good public relations.

Meeting of Council, December 12, 1948 Columbia, S. C.

Present: O. B. Mayer, Chairman, W. W. Boyd, Claud Sease, J. H. Stokes, C. R. F. Baker, J. F. Chapman, R. B. Durham, W. R. Tuten, L. P. Thackston, R. MacDonald, C. S. McCants, Hugh Smith, J. P. Price, and Mr. M. L. Meadors. The following were there by invitation: D. L. Smith, W. A. Black, G. C. Brown, W. A. Hart, J. B. Galloway, A. R. Nicholson.

Hugh Smith, Delegate to the American Medical Association, reported on the recent meeting of the House of Delegates of the AMA. He told of the reasons for the AMA turning down the proposed Blue Cross Blue Shield National Insurance Organization. He also explained the assessment of \$25 which the AMA levied against each member.

Mr. M. L. Meadors told of the recent National Conference on Public Relations held in St. Louis and also of the annual conferences for State Association Secretaries and Editors. The Secretary also discussed certain phases of the meetings in St. Louis and also observations which he had gathered with regard to the situation which confronts the medical profession at the present time.

These reports were followed by a full and lively discussion of recent developments on the national scene and of what might be done in the next few months in the National Congress.

A resolution was presented by MacDonald, which was adopted, calling for the establishment of a speakers bureau within the association and for a plan through which speakers could speak before various non-medical groups throughout the state.

The Secretary then presented a 12-Point Program for activities during the coming months. This was adopted. The Secretary also read a release prepared for newspapers and he was instructed to give this to the press at the proper time.

Following a discussion of public relations, it was moved by Sease and passed that O. B. Mayer, M. L. Meadors and J. P. Price be instructed to investigate a public relations bureau in Columbia and to consider the possibility of using this bureau in our future activity.

Moved by Hugh Smith and passed that the South Carolina Medical Association approve the \$25 assessment made by the AMA upon all of its members and that the South Carolina Medical Association assist in every way possible in getting members to pay this assessment.

The secretary was instructed to send a letter to each County Society with reference to the \$25 assessment, urging that each member pay the County Treasurer, who in turn would send the money to the Treasurer of the S. C. M. A., for transmittal to the AMA. He was also instructed to send a copy of the

12-Point Program, mentioned above, to each County Society.

It was moved and passed that expenses incurred by the South Carolina Delegation at the recent AMA meeting, in St. Louis, be paid.

The secretary read a letter from Mr. J. K. Breedin of Manning asking for a hearing before Council on behalf of his brother, Dr. C. S. Breedin, of Anderson.

Dr. Breedin had asked for reinstatement as a member of the Anderson County Medical Society and his application had been denied. The secretary was instructed to write Mr. Breedin that Council would be glad to hear him on the afternoon of May 16, 1949, at Myrtle Beach, the day before the annual meeting of the South Carolina Medical Association.

There being no further business, the meeting was adjourned.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

THE TIME IS SHORT

The medical profession in the United States is facing immediately the most dangerous fight in its history. One keen Washington observer, connected with the profession but not a doctor, recently made the statement that there is a fifty-fifty chance that a law providing for compulsory health insurance will be enacted by the new Congress. Later he added that in making this estimate he was "being conservative." Some think the chances are considerably more than fifty-fifty in favor of the enactment of such a law.

The background and build-up have been provided by the efforts of the proponents during the past several years. The hearings before the Senate Committees within the past two years on the Wagner-Murray-Dingell Bills have developed volumes of testimony, the major part of which, though much of it biased, is in favor of the proposal. All of the window-dressing is already there.

Last May, on the call of Federal Security Administrator, Oscar Ewing, acting at the suggestion of the President, 800 people, representing most organized groups in the nation, met in a National Health Assembly at the Statler Hotel in Washington to discuss ways and means of improving health and medical care in the United States. Representatives of the Government Bureaus, and those privately-owned groups which favor socialized medicine, predominated.

On September 2nd, Mr. Ewing released to the press his report to the President on the condition of the nation's health, and a ten-year program for its improvement, based largely, he said, on the deliberations and conclusions of the National Health Assembly. The release was perfectly timed in the interest of the Truman political campaign. Undoubtedly, it played a part in the result. Since the election, it has been expressly stated that compulsory health insurance will be one of the objectives high up on the list for the new Congress.

Like Caesar, Mr. Ewing is said to be ambitious—politically. He left a very lucrative law practice in

New York to enter Government service, and you may be sure he didn't do that for "peanuts." Some think he has his eye on the Democratic Presidential nomination in 1952. Espousal of the cause of compulsory health insurance, which he frankly advocates, would be an excellent vehicle on which to ride toward that objective.

When this report was released in September, the newspapers, the radio commentators, the pollsters, were almost unanimous in the belief that liberalism of the New Deal variety was on the way out. Mr. Truman, and Mr. Ewing—of all his official family,—were almost alone in holding the opposite view and having the courage to express it.

November 2nd proved beyond any doubt whose political judgment was sound.

What the newspaper and radio commentators, the pollsters and most of industrial management, business and the professions have failed to realize is that actually we are living in a different era, that the "good old days" in many respects, have gone forever. We have been inclined also to overlook the fact that the change is part of a trend that is world-wide, that has already advanced to a surprising degree, even in a country like England, whose stock is basically the same as ours, and that we in America are a part of One World.

The sad error in the predictions on the result of the recent election was the product of wishful thinking. Unless the doctors abandon the same pastime, look the facts in the face, and do something about it, they are apt to have very soon, an awakening as rude as that of the Republicans on the morning of November 3rd.

Nor is that true only of the doctors. Lenin is quoted as having said that "Socialized medicine is the keystone to the arch of the Socialist State." If medicine goes, it will probably be only a short time before the whole economic system goes. We owe it not only to the profession, but to our country—to our fellow-Americans—to awaken to the realities and to act.

The American Medical Association, although perhaps late, is aroused and is planning its strategy. Your State Association has been awake to the threatening danger, and for the past four years has conducted a program designed to convince the public of the sincerity of the profession and its ability to serve better the interests of the people.

These, however, and every other attempt on the part of the various branches of the profession can be only partially successful without personal, unstinting effort on the part of the individual physician.

There seems little doubt that a definite campaign is under way to discredit the profession. The fact that we have in many respects, a "bad press" is not an accident, nor simply because we deserve it. Enough has been said and published in connection with the efforts on the part of the Federal Security Administration and other agencies to leave little doubt of the fact that certain departments and officials of Government are doing everything possible to influence public opinion in the direction of compulsory health insurance. It has been established that—through the communistic influence or otherwise—even the school books in use in some of the schools of the nation point up the alleged advantages of medical care administered by Government rather than through the private practitioner.

There can be no doubt of the fact that very many, if not most, of the complaints voiced in the press and in magazine articles are unjustified. But the fact remains that there is sufficient ground for complaint to give color and apparent substance to the gross exaggerations voiced by the proponents of state medicine.

And our efforts to develop a "good press" will be of no avail without positive action on the part of the doctors themselves. Human interest is the most appealing quality of any newspaper story. The basic reason why stories and articles adversely criticising the profession are given such prominence, is because almost invariably they involve an element of human interest—the need of an expensive operation, by some poverty-stricken person, the alleged failure of some individual to get a doctor when needed.

In order to get the same prominence for press stories or articles more favorable to the physicians, some of the same elements of human interest must be included. And to be included, they must have a factual basis.

Of course there is ample basis in fact for such human interest stories. But the ethics of the physician prevent his publicizing and capitalizing on the abundant charity work his practice includes. That is a handicap we must accept, and under which we must operate.

Since this handicap cannot be removed it must be off-set. It *can* be off-set and counter-balanced in large measure, by the development on the part of the physi-

cian, of a democratic, personalized interest in his patients, their families and others of the community with whom he is in daily contact.

We have long heard and uttered the familiar reasoning—doctors have been so busy within the past few years discharging their professional duties, that it has been impossible for them to give sufficient time to the human side of the practice. Truly the fault has not been altogether theirs. The demands of the times have been such that it was impossible to show a personal interest in each patient. It was necessary to delegate to office nurses and technical assistants any duties which they could perform, and thereby conserve the time of the physician for other patients and for those other services which no one else could supply.

But, basically, this is one of the main reasons why the profession today finds itself in the present situation. The public does not stop to ask why the doctor cannot take time with each individual patient. A patient who does not receive the undivided attention he thinks his case justifies, becomes impatient, criticises the doctor for a cold-blooded professionalist turning out medical care on the assembly line basis, and damns the profession as a whole. And there are enough of such instances to give substance to such criticism. These are magnified beyond all reason and seized upon and capitalized by the advocates of Government Medicine, as illustrating the unwholesome and unsatisfactory state of the profession as a whole.

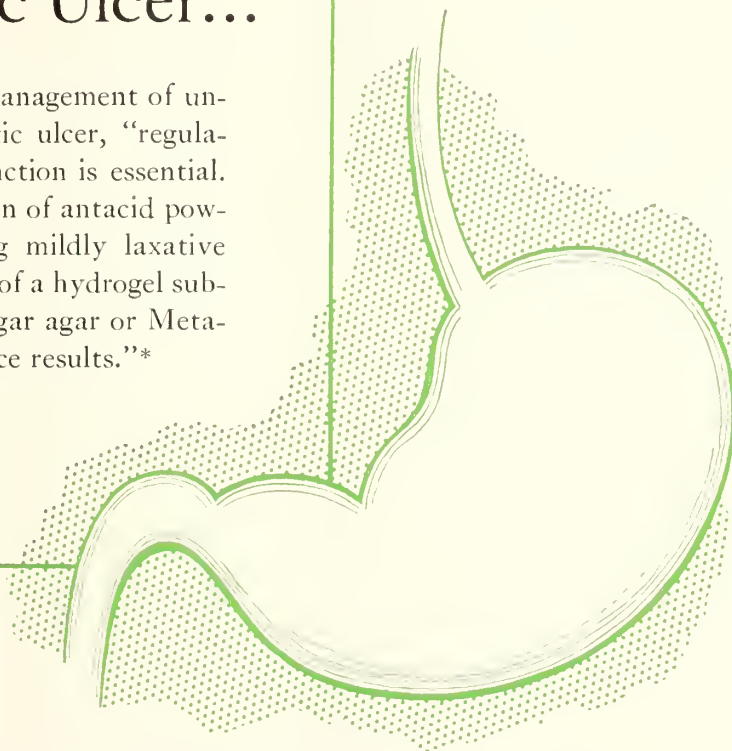
The public needs education, it is true, but all of the articles and the press stories which might be written by a hundred writers, extolling the virtues of the profession and its accomplishments in the past one hundred years, the progress of medical science, the fabulous discoveries, the mastery attained over certain diseases, and the position of America as the healthiest nation in the world,—all of this will not succeed in educating, or changing the minds of the majority of the people, unless the profession can answer the two outstanding objections: (1) How to provide a physician when and where needed, regardless of the time or the circumstances; and (2) How to avoid the high cost of medical care and hospitalization.

These are the basic questions. However just or unjust criticism on these grounds may be in one community or another, they will have to be answered, if the day is to be saved.

The reason why, in the last analysis, the Democrats were elected in November, is that a majority of those who voted think, rightly or not, that they fare better under a Democratic Administration. The reason why the sentiment in favor of Government Medicine has spread and swelled within the past few years, is identical. More and more people have come to think, and are being led to believe that they are not receiving what they are entitled to under a free system of medical practice, and that the ills of which they complain

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

*Gerendasy, J.: Modern Treatment of Peptic Ulcer, J. M. Soc. New Jersey 43:84 (March) 1946.

would be remedied by a system administered by Government.

Unless the rank and file of the profession, unless the individual doctors in the cities and in the rural areas realize the situation and bestir themselves immediately and earnestly to correct this gross misapprehension, it may be impossible to stem the tide.

And time is of the essence .

GOVERNMENT AND PRIVILEGE*

It was Thomas Jefferson who said "That government governs best, which governs least."

Winston Churchill upheld and elaborated that statement when 150 years later, in speaking of governments, he stated that those people who would enjoy democratic freedom with its potential military weakness must keep themselves strong enough to defend their weakness.

That medicine in America enjoys democratic freedom certainly cannot be denied—almost alone in the world today we may still choose the type of work we wish, do it where and for whom we wish, and ourselves set the fee. None but members of the medical profession still remain so completely free to run a "one-man show."

Only recently have we begun to emerge from the "medicine is different" limbo, to realize that freedom is something which must be fought for and protected, even in our own holier-than-thou halls. No longer can we lull ourselves into inactivity with the belief that medicine is set apart from everything else by some unique and God-guaranteed freedom. Yet, too many of us, forgetting that complacency can become an opiate, *still* think a constant chant of past records and present superiority all that is needed to scare away the bad spirits of political bureaucracy.

American medicine admittedly has much of which to be proud, but it must remember that any group which fills its arsenal only with past laurels, becomes static—and in today's world static groups are as dead as the proverbial dodo. No group, nor individual within a group, has any right to boast of accomplishment unless willing at the same time to look for and face weakness and failure. He who is unwilling merely whistles in the dark to keep up his courage.

The weaknesses of American medicine can be divided into two classes, those inherent in human nature itself—that is weakness of the individuals practicing medicine—and those inherent in a group practicing without restraint of regimentation. That we may justify our self praise, let us first turn the light on our weaknesses.

*Reprinted from NEW YORK MEDICINE, November 20, 1948.

I. The Weakness of the Individual Physician.

Charity begins at home; so does constructive improvement. Among the privileges of our profession is that of putting our own price on our services. In line with this is the acknowledged and justifiable practice of the "sliding scale"—payment measured by ability to pay. But by merely changing our term from sliding scale to "all the traffic will bear," we immediately bring in the connotation and raise the question of abuse. In our legitimate practice of the sliding scale, are we always truly considerate, or do we become greedy in our measurement of just what the traffic *should* bear? Let each doctor supply his own answer.

A young man of my acquaintance gave a history of a severe ulcerative colitis, beginning at age eighteen, and lasting through seven years of varied and itinerant, but wholly unsuccessful treatment. At age twenty-five he came under the care of a prominent and able gastroenterologist. In about a year this patient (whose maximum earning expectancy is \$3,000 to \$4,000 per year) was cured of his disease, and left \$1,800 in debt to the physician. Two years later he still owed the physician over \$400. I doubt if this doctor ever realized the size of the burden he had imposed on his patient.

Granted that this case is extreme in degree, it is still too frequent in occurrence. The fact is there are in this country many people who with good reason feel they pay too much for medical care. And perfection of care does not change their feeling, nor have they the slightest interest in any longevity charts or decreased disease tables ever published—it is these people who will be the power behind changing our system of medical practice, unless the individual doctor begins at home and cleans his own house. Cases of excessive charge for medical care are actually rare, yet each case stands out conspicuously, and causes much damage to the reputation of all private medical practice.

II. The Weakness of the Unregimented Group.

When any group functions smoothly and to the benefit of its members, the tendency of the members is to take for granted the running of the group. Such has been the benevolent experience of American medicine. Now suddenly we are yanked from our warm beds by the icy fact that generations of "let George do it" have bred very few Georges for organized medicine.

It is well known that American medical care, albeit the acknowledged superior to any other, still shows discrepancies of distribution. The middle class is sometimes less well cared for than the lower and upper, and may pay disproportionately for care received. Also some rural areas show below average provision for medical care. Largely because the medical profession itself has been slow to face and solve these problems, the ubiquitous seekers of political plums have seized

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From where I sit *by Joe Marsh*

"Husbands, Wives, and Marriage"

Maybe you read that survey published recently in one of the national magazines, entitled "Husbands, Wives, and Marriage."

It showed that among happily married couples, those who criticized *themselves* outnumbered those who criticized the other person. Among unhappily married couples, it was just the opposite—each one tended to criticize the other.

That's the way it is in our town, as I guess it is in yours. Criticism, whether it's of a wife's taste for hats, or a husband's taste for pipe tobacco and an evening glass of beer or ale, is a sure start towards unhappiness.

As for what *made* happy marriages, *companionship within the home* was listed most important of all. And from where I sit, a husband and wife who can spend an evening by the fire—with nothing more exciting than a glass of beer, and a friendly conversation—are a truly well-matched couple!

Joe Marsh

these problems as a wedge for Government medical control.

Those who for political gain would push in Government medicine, ironically enough find their strongest allies in that legion of doctors too indifferent even to get to their Medical Society meetings and find out what goes on. Yet organized medicine, in spite of its late recognition of the weaknesses of an independent medicine, in spite of the continued indifference of many of its members, has already made tangible and constructive reply to the challenge of Government medicine, in the form of voluntary health insurance. The growth of the Blue Cross and its associated hospital plans has been tremendous. There are now over twelve million people protected by voluntary prepaid health insurance, and it is estimated that in three to five years thirty million persons will be so protected. In January, 1944, medical coverage was made complete by combining prepaid medical care with that of prepaid hospitalization. Since the inception of this plan over one million members have taken advantage of it, and the ever-increasing rate of its growth leaves no doubt that ultimately every American citizen can be embraced by this plan.

The American medical profession owes boundless debt to those relatively few medical men who in past years foresaw the threat facing free medicine, and were willing to fight it constructively. The progress already made toward equitable distribution of medical care and costs is due wholly to the untiring efforts of those few physicians.

But the snow-ball of government medicine has rolled too far, to be held any longer by the efforts of these few. The *entire medical profession* must face its shortcomings and correct them. The *entire profession* must act through its medical society units to expand medically controlled, voluntary prepaid health plans to that point which brings the best medical care to every citizen at a cost he can comfortably afford. This goal may sound like the catch phrases so flippantly bandied about by the exponents of political medicine, but nothing short of it will prove strong enough to stem the increasing pressure for government medicine.

And what if we fail to attend meetings and support organized medicine? The handwriting is already on the wall. Vast experience with Government-controlled medicine all over the world, plus every study and analysis of its probable effect applied to American medicine, point to tremendous depreciation and lowering of medical care standards under the State-controlled system.

When a surprised and heart-sick medical profession suddenly awakens to find its freedom taken from it, only to produce incalculable lowering of the value of its services, that profession's pill will not be made less bitter by realizing that it has but itself to blame.

Roger F. Lapham, M. D.

MEDICAL CORPS ENLISTMENTS LAGGING

At the recent interim session of the American Medical Association in St. Louis more than one speaker referred to the urgent need for an immediate increase in the number of enlistments in the Medical Corps of the Armed Services. Dr. James C. Sargent, Chairman of the Council on National Emergency Medical Service, reported to the Conference of Secretaries and Editors of State Medical Societies, on the limited number of such enlistments in the past few months, and the unsatisfactory rate at which this movement was progressing.

It will be recalled that when the current Draft Act was up for consideration in the last session of Congress, concerted effort was called for and was clearly necessary to prevent the inclusion of a provision for drafting doctors in much broader age and dependency classifications than those of the men for regular service. One of the principal arguments used at that time, and one which contributed to the defeat of the proposal, was that no such draft of doctors was necessary, that the medical profession had always voluntarily co-operated to the fullest extent with the Armed Services, and that it could be depended upon to do so in the future.

According to Dr. Sargent's report, and the expressions of others in position to know, up to the present time, this is not working out. In fact, some degree of feeling was expressed by some of the doctors in slightly higher age brackets, who saw active service in the recent war, over the failure of numbers of the younger physicians to volunteer. It was thought, particularly, that those men who have had the benefit of the provisions for G. I. training in the development of their medical education should be among the first to volunteer their services in the Medical Corps of the Army and Navy.

It was definitely pointed out that unless there is an immediate and drastic increase in the number of such volunteer enlistments, assuming that the international situation remains the same or does not improve, the proposal for the same type of drafting of doctors on a broad basis will be renewed in Congress within the next few months, and that such an effort this time, and in view of the record in 1948, will be very hard to defeat.

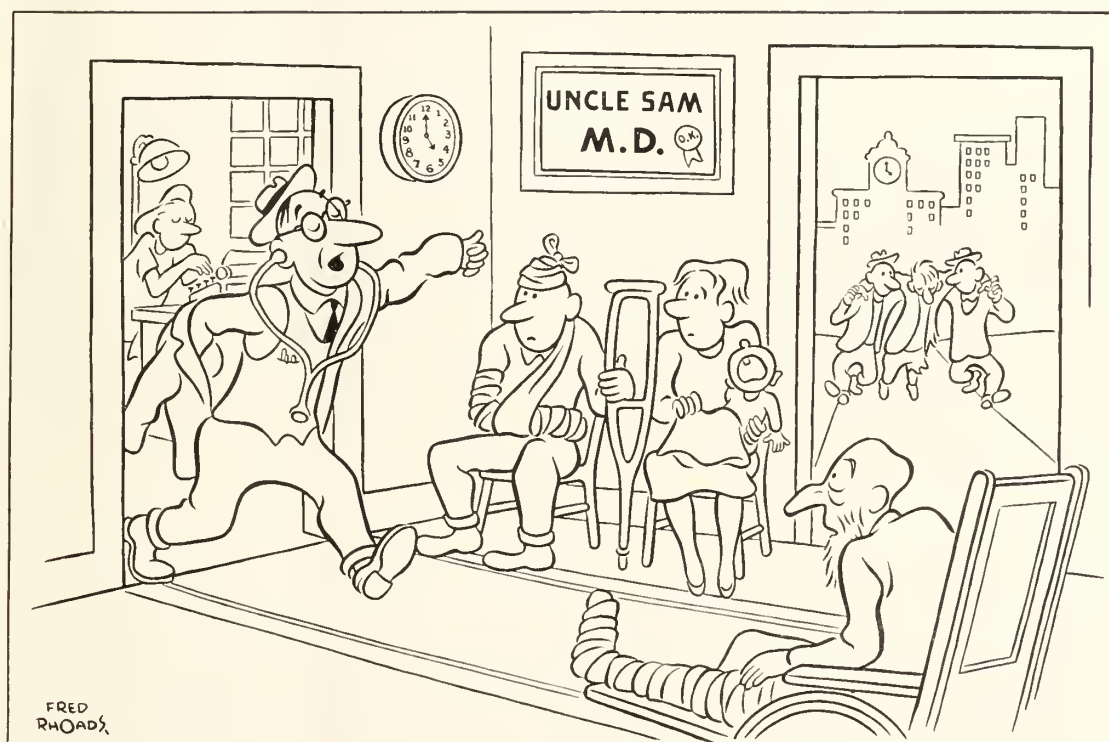
Those who spoke on the subject were insistent that the matter be called to the attention of physicians generally, and particularly to that of the younger men. They felt that wherever circumstances reasonably permit, a special effort should be made by the individual concerned to arrange his affairs so as to be able to volunteer services at the earliest possible time.

ANNUAL MEETING

MAY 17, 18, 19

MYRTLE BEACH

Headquarters - Ocean Forest Hotel



"SORRY, FOLKS. IT'S QUITTIN' TIME."

TEN POINT PROGRAM
of the
SOUTH CAROLINA MEDICAL ASSOCIATION

1. Cooperation

To promote closer cooperation and better understanding between all groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Political Control

To prevent political control or domination of medical practice or of medical education.

3. Study

To assemble and to amplify studies relative to the need and availability of medical care in each county of the state and in the state at large, and to publicize these findings.

To study all agencies in the state which are involved in the administration of medical care as to the type of work which they are doing and the effectiveness of the work which is being done.

To promote plans for providing or improving medical care where there is a need.

4. Care of Indigent

To prepare a uniform plan for the hospital care of the indigent, financed by public county funds, which may be used by individual counties or by groups of counties for their indigent sick, and to promote the general adoption of such a plan.

To promote the establishments of clinics in each county for the indigent ambulatory patients, financed by public county funds and operated or supervised by established hospitals or by the county medical society.

5. Hospital Insurance

To make voluntary hospital insurance available to all the people of the state and to promote the widespread purchase of such insurance.

6. Hospitals

To study the present availability and facilities of hospitals in the state and to promote the establishment of well-equipped and adequately-staffed hospitals in needy areas.

To establish through the State Medical Association standards for hospitals in South Carolina and to make public the names of those hospitals which meet these standards.

7. Group Health Insurance

To promote the establishment of group health insurance plans in all industries, large and small, in South Carolina.

8. Standards for Insurance

To establish standards for insurance companies selling hospital or group health insurance in South Carolina and to publish the names of those who meet these standards.

9. Medical and Nursing Education

To promote the securing of adequate funds and facilities for the operation of the Medical College of the State of South Carolina.

To promote advancement in nursing education and nursing care in the state.

To promote the establishment of a loan fund whereby worthy young men and women of the state who are financially unable to meet the strain of a medical education may be able to secure aid.

10. Education of the Public

To acquaint the citizens of the state with regard to the agencies and facilities in the fields of medical care, public health, hospital and industrial insurance, and to encourage the people to use them on a much greater scale.

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ABSTRACTS

Master, A. M.: Apical Systolic Murmur; Archives of Internal Medicine: 81; 518-533. November, 1918.

The author feels that a loud systolic murmur at the apex should be considered to be organic in nature until proved otherwise. He uses the classification of Freeman and Levine, who divide systolic murmurs into six grades ranging from faint to unusually loud.

Insurance statistics show that the mortality rate for patients with this murmur is increased. For adequate care of these patients it is essential that the murmur be carefully appraised.

A history of rheumatic fever or of infection by group A Str. hemolyticus is almost certain evidence that a defect of the mitral valve exists.

Repeated physical examinations are stressed in doubtful cases. The left lateral recumbent position and the sitting position, with the patient leaning forward and to the left are the most advantageous for eliciting an apical systolic murmur. Amyl nitrite may bring out a long, harsh, prolonged, persisting systolic murmur if the patient is unable to exercise.

Obliteration of the space beneath the left main bronchus by the expanding auricle and "straightening" of the left border of the heart caused by the prominence in the region of the pulmonary artery may be seen in roentgenograms and on fluoroscopic examination.

The phonocardiogram is useful in determining the length of a murmur and the electrocardiogram may reveal abnormal P (auricular) waves and right axis deviation.

The differential diagnosis includes neurocirculatory asthenia, funnel and flat-shaped chests, kyphoscoliosis involving the right dorsal area, hypertension, hyperthyroidism, anemia, and the respiratory murmur.

Transfusions in Newborn Infants Through Abdominal Wall Segment of Umbilical Vein

Louis R. Pinkus. Jour. Pediatrics 33-418 (Oct. 1948)

Part of the difficulty of transfusion of the newborn may be obviated by using the umbilical vein in the abdominal wall, according to the following technique, which carries the factors of safety and simplicity.

A transverse cutaneous incision 2 cm. in length is made 1 cm. cephalad to the upper margin of abdominal insertion of the umbilical cord. Upon separation of the subcutaneous tissue, the umbilical vein is visualized as a whitish, longitudinal, tubular structure elevating the thin midline aponeurosis. A 0.5 cm. longitudinal incision through the aponeurosis is made on either side of the vein, and the latter is easily

freed from the underlying transversalis fascia and peritoneum by blunt dissection with tissue forceps and grooved director. After loose application of a fine silk or catgut ligature around the upper exposed portion of the vein, a sharp-pointed scissors is employed to make a transverse nick through its anterior wall. A blunt-tipped nylon cannula, size 18 (or larger, if desirable), is then introduced cephalad until blood can be aspirated through it with ease. The ligature is then tied with a single hitch to effect snug approximation of the vein wall around the indwelling cannula, and transfusion is carried out. Upon termination of transfusion, the cannula is withdrawn, and ligature is tightened and completed with a second hitch. Skin edges are approximated with two silk sutures.

Bors, E. and Comarr, A. E.: The "Buried Epidermis" Graft, Surg., Gynec., & Obst. 87: 68 July 1948

The authors adapted this method of skin grafting to decubitus ulcers, resistant to other forms of treatment, situated on the sacrum trochanters, knees, ankles, ischium and iliac spines.

The pre-operative care consisted of maintaining protein balance, correction of anemia, and wet dressings to the area involved to provide maximum granulations. It is emphasized that a surprising number of "takes" will result even though the granulation host is poor.

Essentially, the technique consists of removing a split thickness skin graft in one piece with a knife, placing the graft on a wooden board, and dividing it into .3 centimeter squares. These smaller grafts were introduced into the granulating bed with either an instrument or needle where they were retained. It was found best to begin grafting in the most dependent portion of the wound in order to prevent blurring of the field from the unavoidable oozing of blood. The grafts were placed 1 to 1.5 cm. apart. A firm dressing containing equal parts of boric acid ointment and furacin was maintained from 5 to 7 days. Barren spaces may be regrafted in 10 days and complete epithelization was expected in 3 to 6 weeks, depending on the size of the defect.

The chief advantages are the simplicity of the method, the greater number of "takes" varying from 50 to 70%, the resistance to infection and extrinsic damage, and the thriftiness of the method in that the donor area need be only 6 to 8% the size of the defect. These advantages are thought to outweigh the criticism that cosmetic results are inferior.

The authors believe that in all cases of decubitus ulcer where free skin grafting is indicated, the "buried epidermis" graft is far superior to any other type of free skin graft.



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DR. M. J. L. HOYE

Fellow of the
American Psychiatric Association



Happy New Year

With sincere appreciation of the cordial relationship we have enjoyed through the past year, we pause to say thanks, and wish you a NEW YEAR filled with happiness and prosperity.

We look forward to serving you in 1949 in the same friendly way.



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ALBERT F. BRAWNER, M. D.
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JAS. N. BRAWNER, JR., M. D.
Dept. for Women

Leichenger, H. and Schultz A.: Streptomycin in the Treatment of Pertussis. J. of Ped.: 33, 552. November, 1948.

Only patients having uncomplicated whooping cough in either the catarrhal or early paroxysmal stage of the disease as evidenced by two of three diagnostic criteria, (1) positive cough plate; (2) a leucocytosis with a lymphocytosis; (3) typical paroxysms of coughing, are included in this study. For three days prior to treatment the time of each paroxysm and the number each patient had were recorded. Also noted was the occurrence of emesis and all other uncommon phenomena such as convulsions, epistaxis, cyanosis, and apnea.

The patients were then assigned to one of three

groups for therapy. Those in the first group received 1 cc. of a solution of one gram of streptomycin dissolved in 8 cc. of normal saline every three hours by the aerosol route; those in the second group received intramuscularly one gram daily divided into eight equal doses, and those in the third received the usual symptomatic whooping cough treatment of the Cook County Contagious Disease Hospital.

Those patients who received streptomycin showed a more marked diminution in the average daily number of paroxysms and their duration than did the control group.

The authors concluded that streptomycin is effective in the treatment of pertussis particularly when administered by the aerosol route.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. P. M. Temples

Publicity Secretary: Mrs. William H. Folk

Mrs. Powell M. Temples, President, Woman's Auxiliary to the South Carolina Medical Association was guest speaker at the November Meeting of the Woman's Auxiliary to the Spartanburg County Medical Society.

A luncheon honoring Mrs. Temples was enjoyed by members in the Skyline Room at the Piedmont Club. Mrs. Edward H. Law, Vice-President of the Spartanburg Auxiliary, acted as toastmistress. The speaker's table included the following: Mrs. Law, Toastmistress; Mrs. P. M. Temples, State President; Mrs. James D. Nelson, State Corresponding Secretary; Mrs. William H. Folk, State Publicity Secretary; Mrs. W. S. Scott, State Public Relations Chairman; Mrs. Robert Dennis Hill, State Nurse Recruitment Chairman; Mrs. G. B. Hodge, Secretary of the Spartanburg Auxiliary; Mrs. James T. Flynn, Jr., Historian; and Mrs. W. P. Coan who gave the invocation.

The tables were decorated with beautiful arrangements of fruits, berries, and pine interspersed with brass candleabra holding green lighted candles. Mrs. P. A. Smith, Mrs. J. C. Josey and Mrs. Benjamin L. Allen were in charge of decorating the luncheon tables.

Mrs. Law urged Auxiliary Members to become interested and join the League of Women Voters.

Mrs. Temples spoke to the group on auxiliary activities stressing DIPHtheria IMMUNIZATION. Plans are being made with the Public Health Department of South Carolina for the auxiliary to conduct a statewide educational health program on diphtheria immunization.

Mrs. Temples was presented a lovely green leather notebook inscribed with gold bearing her name and date of luncheon as a token of the auxiliary's appreciation of her fine work this year as state president.

There were forty members present for the luncheon.

WOMAN'S AUXILIARY TO THE COLUMBIA MEDICAL SOCIETY

Mrs. Powell M. Temples, state president of the Woman's Auxiliary to the South Carolina Medical Association, addressed the members of the Woman's Auxiliary to the Columbia Medical Society at a large luncheon meeting held by the Auxiliary at the Jefferson Hotel on Tuesday. Mrs. Temples said, "The aim

of the national, state, and county auxiliary this year is to increase membership in all auxiliaries, to promote expansion in the field of preventive medicine, to further the solution of rural health problems, and to continue the nurse recruitment program." She stated also, that to "Study and Educate" should be the 1948-49 slogan of all auxiliaries.

Mrs. Frank Owens, a member of the local Auxiliary, gave an interesting resume of her recent trip to Berck Ber-sur-Mer with Mayor Owens. She gave a detailed account of her visit to the hospitals there and of the maternity ward of a small private hospital in particular. Last year the local Auxiliary assumed responsibility of securing all supplies needed for this hospital ward in the general Berck-sur-Mer collection taken in Columbia.

During the business meeting Mrs. Kirby D. Shealy, president, called for committee reports from the following officers and chairmen, Mrs. H. H. Plowden, Mrs. Weston Cook, Mrs. H. L. Timmons, Mrs. David S. Asbill, Mrs. R. L. Sanders, Mrs. A. T. Moore, Mrs. L. C. Davis, Mrs. A. F. Burnside, Mrs. R. Wilson Ball, Mrs. Thomas Pitts, and Mrs. Gordon Seastrunk.

Eight new members were taken into the Auxiliary at this meeting. They are Mrs. C. T. Weston, Mrs. Pierre LaBorde, Mrs. A. E. Cremer, Mrs. Hawkins K. Jenkins, Mrs. Fred Fellers, Mrs. W. H. Bridgers, Mrs. R. B. Ferguson, and Mrs. DuBose Egleston.

New applicant members present were Mrs. Joseph H. Atwell, Jr., Mrs. Paul C. Wheeler, Mrs. Dana C. Mitchell, Mrs. Cliff Rathliff, Jr., and Mrs. C. Benton Burns.

Honorary and out-of-town guests attending the luncheon were, Mrs. W. H. Folk, State Publicity Secretary, Mrs. Charles Kendall, Mrs. W. J. Shealy, Mrs. R. S. Watkins, Mrs. R. W. Houseal, Mrs. B. Graham, and Mrs. R. P. Burbage.

MEDICAL AUXILIARY HEARS MRS. POWELL M. TEMPLES

The Women's Auxiliary of the Anderson Medical formally resumed its work for the year 1948-49 at a lovely luncheon held at the Calhoun Hotel at which time the auxiliary was honored by the presence of Mrs. Powell M. Temples of Spartanburg, president of the Women's Auxiliary of the South Carolina Medical Association. Mrs. Temples was introduced by Mrs. Sam Orr Pruitt, president, who presided at the affair.

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JOHN R. SAUNDERS, M.D.

THOS. F. COATES, JR., M.D.



L I T E R A T U R E O N R E Q U E S T

Mrs. Temples' address centered on an outline of plans for the auxiliary during the coming club year. Of particular local interest is the plan of the Anderson Auxiliary to sponsor a canteen at the Anderson Memorial Hospital to service the nurses, visitors at the hospital, and the public in general. It is the hope of the auxiliary to get hereby raise money for its organization, as the plan has been successfully adopted by a number of similar auxiliaries.

A delicious four-course luncheon was served during which time a number of guests were recognized. Among these were Mrs. W. H. Folk, of Spartanburg, former president of the state auxiliary, presently the state publicity chairman; Mrs. Harry Ross of the local auxiliary, also a former president of the state organization; Mrs. Ruth Birthright, Superintendent of Nurses at the Anderson Memorial Hospital; Mrs. W. E. McCurry and Mrs. Hubert Milford, both of Hartwell.

Mesdames McCurry and Milford, wives of Hartwell physicians have been asked to join the auxiliary as associate members.

President: Dr. Z. W. Gramling
Vice-President: Dr. E. B. Ellis
Secretary-Treasurer: Dr. J. S. Garrison

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DEATHS

WILLIAM EVANS LESTER

Dr. William E. Lester, 60, died at the Mullins Hospital, December 11, after suffering from a serious cardiac condition for the past six months. A native of Marlborough County, Dr. Lester received his education at Wake Forest College, the University of North Carolina and was graduated from Tulane University School of Medicine (Class of 1911). He did post-graduate work at the children's hospital in Chicago and the Presbyterian Medical Center in New York City. He served in the armed forces during World War I and was overseas for eighteen months. He had practiced medicine in Mullins for the past eighteen years.

Dr. Lester is survived by his widow, the former Miss Emily Dean Smigh of Greer, and one daughter, Miss Elizabeth Evans Lester.

NEWS ITEMS

The following county medical society officers have recently been elected to serve during 1949:

Greenville County Medical Society:

President: Dr. Charles Wyatt
President-Elect: Dr. R. L. Cashwell
Vice President: Dr. J. E. Crosland
Treasurer: Dr. J. E. Lipseombe
Secretary: Dr. Horace Whitworth

Chester County Medical Society:

President: Dr. Conrad Smith
Secretary-Treasurer: Dr. Malcolm Marion

Ridge Medical Society:

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Advances in Therapeutics: During the Life of the Pee Dee Medical Association

By
OSCAR W. BETHEA, M.D.
New Orleans, La.

The advances in Therapeutics have been so great during the hundred years of the life of this association that I can call attention to only a few highlights of the major developments.

It is probable that until 150 years ago the sum-total of therapeutic effort resulted in more harm than good. We have a vivid illustration of this in the final illness of our greatest American, George Washington. He probably had a streptococcal throat and was attended by three of the ablest physicians available. We do not know all that was done during the less than 24 hours of treatment, but two of the physicians reported the following facts. There were four bleedings; the amounts of blood removed during the first three is not stated, the last was thirty-two ounces. He was given three doses of calomel; the amounts of the first two are not stated, the last was 10 grains. He was given repeated doses of tartar emetic totaling "5 or 6 grains." Blistering agents were applied to the neck and to all extremities. Frequent inhalations of vinegar and steam were used. At least one enema was employed.

Until about that time antimony had been the most popular agent in medicine for two hundred years,¹ but was not used for any of the conditions for which it is now recommended.

When this association came into being fever patients were starved; bleeding, purging, sweating, dueresis and emesis were the mainstays of treatment. In Ebert's Prescription Survey of some 60 years ago opium or its derivatives were ordered 197 times in each 1000 prescriptions.² Calomel was the magnum donum Dei for treatment.

Fifty years ago I was working in a pharmacy that filled the prescriptions for a large college for women. The school physician's favorite remedy was a special capsule that was used so often that on days when

business was dull we made them up 100 at a time. Each capsule contained 1 grain of opium and 20 grains of calomel.

Less than twenty years ago one of our greatest medical writers³ was predicting a brilliant future for lobelia. This drug has now joined sassaparilla, stillingia, echinacea and the hundreds of other former standbys of treatment, in becoming "of historic interest only."

If the physicians of the preceding centuries were not doing so much to prolong life and promote comfort they were at least laying the foundation on which was built the splendid structure of today.

Jenner made his first report on small pox vaccine in 1796. However, it has been during the lifetime of this association that vaccination was employed in a practical way. Small pox that formerly killed or disfigured one-fourth of the human race has practically disappeared from civilized countries.

Ether was used by Long in 1842 and Chloroform by Simpson in 1846, but this association has witnessed all of the practical developments in anesthesia. For example, the bitter opposition to the use of anesthesia in childbirth, by both church and laity, did not begin to subside until Queen Victoria accepted the use of chloroform for the delivery of her seventh child ninety-five years ago.

Ninety-eight years ago Gorrie, a Florida physician, announced his development of a process for making ice, and outlined air-conditioning. In both of these his objective was promoting the comfort of the sick. Just think how much they have contributed to many departments of medicine.

Ninety-six years ago the great architect, Sir Christopher Wren, invented the hypodermic syringe. The developments based on his modest beginning have made modern therapy possible.

(Presented at Centennial Meeting, Pee Dee Medical Association, November, 1948).

This organization has witnessed the epochal work of Pasteur and others in beginning our knowledge of micro-organisms and the practical application of these findings by Lister and those who built upon his pioneer efforts.

Sixty-four years ago local anesthesia began with the report of Koller on the use of cocaine.³ In the intervening years better agents have been developed and the purely local use has grown into regional and spinal anesthesia. Now the administration of such preparations has become a highly complex speciality.

Fifty-three years ago Roentgen made his first report on a ray that for want of a better name he called "X" (the unknown). This not only opened up a new field of therapy but, by removing much of the element of guess from diagnosis, made other phases of treatment more available and effective.

Later the Curies through the discovery of radium largely supplemented and expanded the related fields of therapy.

Two of the truly great advances in medicine were the passage of the Pure Food & Drug Law 42 years ago, and the Narcotic Law that followed eight years later. Only one who was in the practice of pharmacy before that period could truly evaluate what these measures meant to the people of America. Two illustrations may help us:

A "Lithia water" was being extensively advertised and used for various and many diseases. It was said to have more testimonials from distinguished physicians than any "remedy" known. When the law came into effect the analysis of this water was made public. It has been stated that it contained one-fifth as much lithia per gallon as the Potomac River as it flowed by Washington. If Father Abraham, when he was called out of Chaldea nearly 4000 years ago, had started taking a half gallon a day and continued to the present time, he would not have had one days dosage of lithia, and if he had reached that goal it would not have affected any disease process known to science. No better proof of the need of Pure Food and Drug Law could be asked than the fact that practically every manufacturer of medicines for general sale had to change many labels and much advertising matter.

I once worked as a prescription clerk in a small city where there were twenty-seven physicians. Nine of them were known to be morphine addicts, and four had one or more members of their own households on the drug. Think what must have happened to their patients.

Thirty-nine years ago Ehrlich introduced the first of the arsphenamines for syphilis, which was followed in about ten years by the use of bismuth in France. The benefit of these and other newer agents on our generation is but a trifle as compared to the sum total of protection to the billions yet unborn.

One advance that has never been given sufficient emphasis was the nasal tube. Levin the inventor re-

ceived only limited recognition. This device was not only one of the greatest steps forward in the study of the stomach since the work of Beaumont, but it revolutionized many phases of therapy and has prolonged countless thousands of lives. For example, the patient who could not be given oral feedings simply starved. The Murphy drip or retention enema might help some for a time; and very recently the intravenous route can be used for a considerable period, but these measures do not meet the requirements of the patient who must have food and water by artificial means for weeks or months. There was a time when students were told that in tetanus it was often necessary to remove sufficient teeth to make feeding possible. Those who can remember the old Ewald tube, passed through the mouth, can appreciate the work of Levin.

Twenty-six years ago Banting and Best reported the isolation of Insulin, and the diabetics of the world, for the first time in history, could look to the future with the assurance of a fair measure of comfort and a reasonable life expectancy. Before this I had never seen a case of diabetic coma recover. Now Joslyn⁴ can report a series of 62 consecutive cases without a fatality.

Following the experimental work of Whipple, liver extract was shown by Minot and Murphy to be specific for certain forms of anemia. Now pernicious anemia, sprue and some other related conditions have joined the growing list of diseases for which we have specifics.

Immunization was mentioned in referring to vaccination against smallpox. A few other illustrations will indicate what has been accomplished during the lives of many of us here today.

While diphtheria antitoxin was reported by Von Behring in 1890, it was 1907 before active immunization was presented by Theobald Smith, and it was 1915 before its practical use was established by Park. Fifty-years ago in New Orleans the death rate per 100,000 from diphtheria was 51.3. Last year it was 1.2, and this was largely due to late out-of-town cases being sent to our Charity Hospital.⁵ Thirty-nine large cities in the United States had no deaths from diphtheria last year.

Typhoid fever fifty years ago carried a mortality of about 25 percent. Coleman and his associates,⁶ by advocating the omission of empirical medication, and the proper feeding of patients, reduced the mortality to about 5 percent.^{7, 8} Immunization with the bacterial vaccine has accomplished even far greater results. For example during the Spanish-American War, fifty years ago, there were 141.59 cases per thousand among American soldiers. During the first World War twenty years later, the rate was 0.37.⁹ Thirty-six cities in our country had no deaths from either typhoid or diphtheria last year.⁵

The value of antitoxin in the treatment of tetanus is still a moot question but this agent in passive im-

immunization, and the toxoid in active immunization, have been established beyond dispute. For example during the first World War the German army lost 300 soldiers by tetanus for every 100,000 wounded. During the recent war our navy had about 90,000 wounded personnel and lost two from tetanus. The records indicate that probably neither of these had received the course of toxoid.¹⁰

The name "vitamin" was not even coined until Funk suggested it 36 years ago. Now pellagra, scurvy and many other diseases are prevented, cured or benefitted by the use of these agents as such, or by proper diet. Add to this the millions of dollars made by the manufacturers and the untold pleasure experienced by the public in swallowing these relatively harmless products. We are learning that "The best way to take vitamins is with a knife and fork."

The past twelve years have marked a new era in treatment. This began with the sulfonamides. While the first of these was reported in Germany in 1935 it was not until Long and Bliss published their study of sulfanilamide in 1936 that it commanded serious attention here. The practical use of these preparations really began when sulfapyridine was developed in England and sulfathiazole in Sweden just ten years ago. The real impetus came two years later when Robin synthesized sulfadiazine and Marshall sulfaguanidine. Each year since has seen not only new related preparations but a better understanding of the uses and the limitations of the various members of this group. It may be well to consider the therapeutics of the sulfa drugs with the antibiotics.

Fleming published his first report on penicillin nineteen years ago, and while he suggested then, and two years later, that it had therapeutic efficiency nothing was done about it until ten years later when Dubos in this country published his studies on tyrothricin. Florey and his associates at Oxford then took up the study of penicillin. Due to war conditions in England further development was transferred to this country where it was carried to a brilliant consummation.

The search for other related products was then undertaken in a large way and four years ago Waksman at Rutgers University isolated streptomycin. The search for better antibiotics is still on.

In this connection allow me to quote from a price-less Editorial in the *Annals of Internal Medicine* of August 1946:

"Streptomycin, then, is here to stay, at least until some superior antibiotic preparation comes along to supersede it. And if such a super-drug is developed, it too will in all likelihood emerge from the earth under our feet. To one with a philosophical twist, it must seem mildly entertaining to reminisce over the major advances in antibiosis during the past twenty years. Starting with the pneumococcal polysaccharide-splitting enzyme culled from a cranberry bog, we have seen gramicidin, tyrothricin, penicillin, strepto-

thricin, and finally streptomycin 'sprout' from the soil in rapid succession. At the rate things are going the bacteriologists and chemotherapists may soon supplant the sociologists as the prime supporters of the 'back-to-the-soil' movement."

These new chemotherapeutic and antibiotic agents have revolutionized therapy. A text book on treatment written ten years ago is hardly worth a place on our shelves, much less on our desks. A few data will illustrate what has been and is being accomplished.

Pneumonia had been called "the old man's friend" because of its tendency to end his weary journey toward the sunset. It was no respecter of persons. It was the scourge of all ages and conditions of the race of men. Twenty years ago in preparing a paper on the treatment of this disease I secured statistics from a large group of the older hospitals of this country. The data covered many thousands of cases and represented ten year periods going back fifty years. The mortality was about 35 percent and showed no improvement during the time covered.¹² Now some of our most reliable clinicians are reporting such results as the following:

94 cases treated with sulfadiazine—9.6 percent mortality; 94 cases treated with sulfadiazine and penicillin—4.3 percent mortality.¹³

109 cases treated with intramuscular penicillin—8.3 percent mortality; 59 cases treated with oral penicillin—5.1 percent mortality.¹⁴

677 cases treated with sulfadiazine—no deaths; 195 treated with sulfadiazine and penicillin—6.7 percent mortality.¹⁵

It is probable that in the best hands the present mortality of pneumococcal pneumonia is between 6 and 8 percent. Corresponding improvement has been made in other types of the disease.

When some of us began the practice of medicine meningococcal meningitis carried a mortality of about 75 percent. The specific serum developed by Cole reduced this to about 25 percent. Now we can read reliable reports showing such results as follows:

30 cases—no deaths¹⁶

37 cases—no deaths¹⁷

63 cases—no deaths¹⁸

150 cases—6 deaths¹⁹

Today the average mortality in medical centers is probably below 5 percent.

Treatment results in other types of meningitis show varying degrees of improvement.

Before the advent of the sulfa drugs I had never known a patient with subacute bacterial endocarditis to recover. I later saw one case survive apparently as a result of the use of one of the sulfonamides. I have heard of one or two other instances. The mortality had probably changed from 100 to about 98 percent.

Some recent reports read:

25 cases—28 percent died²⁰

17 cases—17.6 percent died²¹

12 cases—8.3 percent died²²

The present mortality of this disease is probably below 25 percent and improving slowly but surely.

During the lifetime of this splendid organization, therapy has made advances that stagger the imagination. When this group came into being the life expectancy in the United States was somewhat uncertain. It has been estimated at 34 years. Fifty years ago it was 41.5 years, now it is 67 years.

Allow me to give some data from New Orleans.²³ In 1847 the death rate from yellow fever was 3800 per 100,000. There has not been a case of yellow fever in the city in 43 years. In 1929 the death rate from cholera was 2500 per 100,000. There has been no death from cholera there in the twentieth century. One hundred years ago the death rate per 100,000 from tuberculosis was over 480. Last year it was 58.8 and this was largely due to out of town patients coming to our hospitals. Deaths from typhoid fever have been reduced to less than 2 percent of the rate of a century ago.

Maternal mortality has dropped to about 15 percent and infant mortality to 24 percent of what it was in our city when your association was organized.

Yes—much has been accomplished but many unsolved problems remain for the future. Let these be to us both a challenge and an inspiration.

1. A sketch of medicine and pharmacy: Massengill, S. E., 84-85, 1943.
2. The Prescription Ingredient Survey: Catharcoal, E. N.; Am. Phar. Assn.—1933.
3. Origin and History of Pharmacopeical Vegetable Drugs: Lloyd, J. U.; The Caxton Press, Cincinnati, 1929.
4. Diabetic Coma: Joslyn, E. P. et al; J. A. M. A. 119:1160 August 8, 1942.
5. Special Article: J. A. M. A. 137:1525 (Aug. 21, 1948).
6. Treatment of Typhoid Fever: Coleman, W. and Shaffer, P. A.; Arch. Int. Med. 4:538, 1909.
7. The Therapy of Typhoid Fever: Bethea, O. W.; Int. Med. Digest, 28:245, April, 1936.
8. Typhoid Fever: Musser, J. H.; Piersol's Cyclopedia of Medicine, etc., Vol. 15, P. 501, F. A. Davis Co., Philadelphia.
9. Typhoid and Paratyphoid Fever: Siler, J. F. and Lambie, J. S.; Communicable and Other Diseases,

Vol. 9, p. 15—1928.

10. The U. S. Navy's War Record with Tetanus Toxoid (Feb.): Hall, W. M.; Ann. Int. Med. 28:298—1948.
11. Streptomycin Editorial, Ann. Int. Med. (August) 1946.
12. Treatment of Pneumonia: Bethea, O. W.; J. A. M. A. 95:925 (September 27th), 1930.
13. Penicillin and Sulfadiazine Compared with Sulfadiazine Alone in Treatment of Pneumococcal Pneumonia: Dowling, H. F., Hussey, H. H., Hirsh, H. L. and Wilhelm, Frieda; Ann. Int. Med. 25:950, December, 1946.
14. Treatment of Pneumococcal Pneumonia with Oral and Intramuscular Penicillin: Dowling, H. F., Rotman-Kavka, Georgine, Hussey, H. H., and Hirsh, H. L.; Am. J. M. Sc. 213, April, 1947.
15. Combined Penicillin and Sulfadiazine Therapy in Pneumococcal Pneumonia: Collen, M. F., Sellers, A. L. and Kast, E. C.; Am. J. M. Sc. 211:290, March, 1946.
16. Meningococcal Meningitis: Kinsman, J. M. and D'Alonzo, C. A.; Ann. Int. Med. 24:606, April, 1946.
17. Meningococcal Infections with Special Reference to Certain Diagnostic Considerations: Analysis of 37 cases: Oxman, A. C. and Fischer, I.; Ann. Int. Med. 23:924—December, 1945.
18. Meningococcal Infections in Army Staging Area: Analysis of 63 Cases Without Fatality: Goldbloom, A. A., Nickman, E. H. and Seidman, E. E. P.
19. Meningococcal Meningitis: Meyer, A. H., Ann. Int. Med. 22:543, April, 1945.
20. Cardiac Failure in Penicillin-Treated Subacute Bacterial Endocarditis: Fiese, M. J.; Arch. Int. Med. 79:436, April, 1947.
21. Treatment of Bacterial Endocarditis with Penicillin: Results in 17 Unselected Cases: Makotoff, R., Brans, W., Katz, L. N. and Howell, Katharine; Am. J. M. Sc. 211:395, April, 1946.
22. Treatment of Subacute Bacterial Endocarditis with Penicillin: Report of Cases Treated Without Anticoagulant Agents: Goerner, J. R., Geiger, A. J. and Blake, F. G.; Ann. Int. Med. 23:491, October, 1945.
23. Personal Communication: Whitney, John M., Supt. Public Health, New Orleans, La.

Ectopic Pregnancy: Analysis of 100 Consecutive Cases

JOHN E. ZELIFF, M.D.
ROYCE B. MEANS, M.D.
HEYWARD H. FOUCHE, M.D.
Charleston, S. C.

Ectopic pregnancy is one of the most commonly misdiagnosed disorders of the female pelvis.¹ It may be confused with a variety of conditions which should properly be treated by the internist, the surgeon, or other specialist. Novak speaks of it as a "disease of diagnostic surprises."² We have analyzed the records of 100 consecutive ectopic pregnancies at Roper Hospital with the specific purpose of noting the atypical findings and errors in diagnosis and treatment. Two full term abdominal pregnancies during the period covered in this series are not included and are to be reported elsewhere.

The youngest patient in the series was 15 years old. The oldest was 42 years of age. The average age was 27. Sixty-seven of the patients were of the negro race and thirty-three were white. Seventy-two of the series had at least one living child; twenty-eight had no living children.

TABLE I
Possible Predisposing Factors in 100 Ectopic Pregnancies

Factors	Total Cases			
	White		Colored	
	No.	Per Cent	No.	Per Cent
Previous Abortion	8	24	20	29
Chronic Salpingitis (Histologic Exam)	10	32	32	47
Endometriosis	2	6	0	0
Previous Laporotomies	13	39	3	4
			(Previous ectopic pregnancies)	
Fibromyomata Uteri	4	12	4	5

POSSIBLE PREDISPOSING FACTORS (Table I):

Of the possible predisposing factors, chronic salpingitis was most commonly found (42 cases). A history of previous abortion was not found more frequently in these patients than in a comparable group of early pregnancies. Sammartino and Gori (3) report 16% of their patients showed endometriosis, while only two of our cases showed evidence of this disorder. Only three colored patients in the series had had previous laporotomies; it is of interest to note (From the Department of Obstetrics and Gynecology of the Medical College of the State of South Carolina and the Roper Hospital, Charleston, S. C.)

that these had been done for ectopic pregnancies. Previous laporotomies on 13 white patients were done for various reasons, but none was operated on for ectopic pregnancy.

DIAGNOSIS:

The typical signs and symptoms of ruptured ectopic pregnancy include four that may be considered cardinal: Amenorrhea, abdominal pain, abnormal vaginal bleeding, and an adnexal mass.^{1, 2, 4} These are more or less typical of the acute case. Those cases which have been ruptured over 48 hours are arbitrarily spoken of here as chronic ectopic pregnancies. In these cases the symptoms are much more varied and the diagnosis more difficult.¹ It was found that only 21 cases of the series might be considered acute.

The high incidence of chronic ectopic pregnancies in this series (79%) may be due to the fact that most of the patients included come from the low income group, and usually delay seeking medical advice as long as possible. However, in the series reported by Atlee,¹ 67% of the cases were of the chronic type.

Amenorrhea.—

While amenorrhea is a very important symptom, its absence in no way excludes the diagnosis of ectopic pregnancy. Eleven of the 19 cases with a normal menstrual history were misdiagnosed. Amenorrhea was present in 50% to 90% of the cases reported in other series.^{1, 5}

Abdominal Pain.—

Abdominal pain of varying character was a constant feature. Most often it was of sharp recurrent nature, and present in both lower quadrants.

Abdominal tenderness was found in 89 of our patients. It was severe in 77. Tenderness was absent in 5, and was not recorded in 6. In this analysis the records were not sufficiently complete to draw any conclusions as regards either muscle spasm or rebound tenderness. In our experience, muscle spasm and rebound tenderness without muscle spasm are often found.

Vaginal Bleeding.—

Vaginal bleeding varied from complete absence to a profuse flow. While the patient most often described it as intermittent spotting, it not infrequently came as a large flow or gush of blood. This bleeding is theoretically due to a casting off of the decidua upon death of the fetus.⁶

In 19 cases there was no abnormal bleeding. Spotting occurred in 41; bleeding was considered essentially a normal flow in 23; and in 17 there was profuse bleeding. In 50 patients the bleeding was intermittent and occurred on two or more occasions. These patients were frequently diagnosed as abortions and were treated as such. Eighty-two of the patients always had normal menses prior to the occurrence of the ectopic pregnancy.

Pelvic Examination.—

Pelvic examination showed an adnexal mass in 70 patients. Tenderness on pelvic examination was marked in 32, moderate in 27, and slight in two patients. In three of the chronic cases there was no tenderness. In 22 cases the presence or absence of tenderness was not recorded. Pelvic examination was omitted in 14 cases with an obvious diagnosis for fear of causing further bleeding in an already exsanguinated patient.

A tender adnexal mass and a normal or slightly enlarged uterus is a typical finding.^{4, 5} Marked tenderness frequently prevents the discovery of an adnexal mass unless the examination is done under anesthesia. Extreme tenderness and at times crepitation in the cul-de-sac is noted on recto-vaginal examinations.

ADDITIONAL POINTS IN DIAGNOSIS:

Shock—Symptoms of peripheral vascular collapse were found in 38 cases on admission. Twenty-eight of the entire series described attacks of weakness or faintness and 19 had subnormal temperature on admission.

Shock and symptoms of further bleeding frequently occurred following pelvic examination. In 9 of the patients the hemoglobin fell markedly following examination and symptoms of an abdominal emergency were exacerbated. Any case of suspected ectopic pregnancy should be carefully watched for signs and symptoms of shock after vaginal examination. It must be remembered that, in the presence of shock, signs and symptoms may be greatly modified, tending to minimize pain and tenderness which would otherwise be present.

Gastro-Intestinal Symptoms.—Forty-six patients described either nausea or vomiting associated with the onset of their illness. However, this followed no particular pattern and was in no way typical or diagnostic. It has little value in differentiating ruptured ectopic pregnancy from appendicitis.

Pain on defecation has been mentioned as being of diagnostic significance. In our series this symptom was of little help.

Temperature.—Admission temperatures are summarized in Table II. Fifteen of the patients with circulatory collapse had temperatures below 98.6°. It will be noted that the preponderance of elevated temperatures is seen in the chronic type, although elevations as high as 102 degrees are sometimes seen in the acute case. Subnormal temperatures are not

TABLE II

Admission Temperatures in 100 Consecutive Ectopic Pregnancies

Degrees Fahrenheit	Acute	Chronic
Below 98.6	10	19
98.8-100	10	44
100.2-102	2	14
Above 102	0	1

TABLE III

Hemoglobin Determination On Admission (Haden-Hauser)

Gms. %	Acute	Chronic
1-3	0	3
4-6	3	11
7-10	17	44
11-14	0	20
Not Recorded	1	0
Low	4.5	2.1
Average	8.3	8.6

infrequently seen in the presence of peripheral vascular collapse.

Laboratory Data.—In Table IV leukocyte counts on admission are summarized. In Table III the hemoglobin determinations on admission are summarized.

It is interesting to note that the average hemoglobin in acute and chronic cases was essentially the same.

The red blood count and hemoglobin values was usually definitely lowered. In many instances, however, the first hemoglobin determination cannot be trusted because the blood volume has not been re-established when the specimen of blood is examined. Clinical estimates by the color of the conjunctivae,

TABLE IV

Leukocyte Count on Admission

WBC/cu mm	Acute	Chronic
6,000 & Below	0	8
7,000-10,000	3	28
11,000-15,000	17	27
16,000 & Above	1	26
High	46,000	40,000
Low	9,000	4,000
Average	17,000	12,300

finger nails, and mucus membranes of the tongue are often more accurate at this time. The leukocyte count varied from normal to very high levels; leukocytosis of 12,000 to 14,000 was usual in both acute and chronic cases.

TABLE V
Incidence of Signs and Symptoms in Patients with Ectopic Pregnancies
in Whom an Incorrect Diagnosis was Made

Signs & Symptoms	Admission Diagnosis				
	Salpingitis	Incomplete Abortion	Fibroid	Ovarian Cyst	Appendicitis
Amenorrhea	15	4	1	3	3
Vaginal Bleeding					
Vaginal Spotting	8	2	2	2	2
Profuse Bleeding	6	0	0	0	0
Shock	3	1	0	0	0
Pelvic Tenderness	7	0	0	0	2
Leukocytosis	7	3	2	2	1
Fever (Temp. above 98.6° F)	15	3	3	0	1
Anemia (Hgb. below 10)	14	3	3	1	3

OTHER DIAGNOSTIC PROCEDURES:

Posterior colotomy was done in 6 cases with positive diagnostic results and failed in 1 case later proven to have hemoperitoneum. This may be performed either by incision in the posterior fornix or by aspirating the cul-de-sac with a needle of large bore. Some authors maintain that the value of this procedure is limited⁸ and that morbidity is increased by it.^{5, 8, 9} Its greatest value probably lies in differentiating inflammatory cysts or pelvic abscess from ectopic pregnancy.

In 8 of our cases pregnancy tests were performed. These were positive in 6 instances, negative in 1 and doubtful in 1. The 2 hour rat test is particularly useful because of the rapidity with which it may be performed.¹⁰ A positive report is of definite value, a negative one calls for reconsideration of the history and physical examination.¹¹

Whitacre, et al,⁶ have recently described a procedure for determining hematin in blood following enzymatic destruction of intraperitoneal blood after a ruptured ectopic. In the 2 instances in which we have tried this we have obtained equivocal results.

PRE-OPERATIVE DIAGNOSIS:

35 patients had sought medical attention before being admitted. Thirty patients were seen once, 2 were seen twice, 2 were seen three times, and one patient had been seen 5 times. To emphasize the difficulties encountered it may be noted that dilatation and curettage was performed on three occasions for incomplete abortion before the diagnosis of ectopic pregnancy was made.

In 63 cases a primary diagnosis of ectopic pregnancy was made prior to operation. Ectopic pregnancy was considered strongly in 6 of the remaining 37 who were erroneously diagnosed. Erroneous diagnosis included chronic salpingo-oophoritis,²⁰ threatened or incomplete abortion,⁵ fibromyomata uteri⁴ appendicitis or appendiceal abscess,³ ovarian cyst,⁴ and acute abdominal hemorrhage.¹ The occurrence of

signs and symptoms in these groups is summarized in Table V.

TREATMENT:

Ninety-nine cases were operated upon, one having died before the operation was performed.

Sixty-one of the patients received transfusions. Thirty-six transfused pre-operatively, 28 during the course of the operation, and 33 following operation.

Operation was limited to salpingectomy or unilateral salpingo-oophorectomy in 61 cases. The contralateral tube was removed in 24 cases for chronic inflammatory disease; appendectomy was performed in 10, and hysterectomy in 5 cases for complicating fibromyomata. The shortest operation was 18 minutes and the longest 1 hour and 45 minutes.

The treatment of ectopic pregnancy follows two principles: First, adequate whole blood transfusions, and second, early operation. If shock is present, treatment should be instituted immediately. The danger of raising the blood pressure and thus causing further bleeding is far less than the danger of the initial shock becoming irreversible. Plasma should be used if whole blood is not available. In the event that the blood pressure is stabilized, transfusion might well be delayed until operation is begun. In the presence of marked circulatory collapse, operation should be delayed in order to allow some response to treatment. If no response is seen in a short time, operation should be done immediately. Whole blood may be pumped into the vascular system by syringe if the usual drip method is not sufficient to replace the blood loss.

OPERATIVE FINDINGS:

The ectopic gestation occurred in the right tube in 49 cases, in the left in 47, 3 were not described, and one was not operated upon. The tube was ruptured in 76 cases, unruptured in 11, and 9 were tubal abortions, 4 were not described. There were two proven cases of cornual pregnancy. In a few cases¹¹ there was no

hemoperitoneum. The maximum amount present in the peritoneal cavity was 2000 cc's. Adhesions varied in direct proportion to the amount of pre-existent inflammatory disease and the length of time hemoperitoneum was present. They were recorded as being present in 58 cases.

CONCOMMITANT OPERATIONS:

At operation the amount of surgery done is entirely dependent on the condition of the patient at that time. A study of the morbidity and mortality in this series showed no variation regardless of the multiplicity of procedures. This, in general, agrees with the observation of MacFarlane and Sparling⁸ that concomitant operations do not affect the morbidity, mortality, or length of hospital stay of the patient.

MORTALITY:

The three cases in our series who died were of the negro race. In the three cases which terminated fatally, the cause of death in each was as follows: 1) Sudden onset of pulmonary edema, three hours post operatively, after receiving 4,500 cc's fluid in 12 hours (including one auto-transfusion); 2) delayed surgical intervention (the patient dying during operation), which had been delayed 18 hours after admission because of the patient's grave condition. She had received one transfusion before operation; 3) delayed surgical intervention because of the poor condition of the patient and an inadequate supply of blood. In the 101 fatalities studied by Williams and Corbit,¹² it was found that the ratio of ectopic deaths to puerperal deaths is twice as high in negroes as in the white race.

SUMMARY:

1. One hundred cases of ectopic pregnancy have been reviewed.
2. In this series there were 21 so called acute ruptured pregnancies and 79 chronic ectopic pregnancies.

3. Points to be considered in the diagnosis of ruptured ectopic pregnancy have been discussed in relation to the group of cases reported.
4. Treatment in relation to the reported group of cases is discussed.

BIBLIOGRAPHY

1. Atlee, H. B.: Ectopic Pregnancy as a Diagnostic Problem: Study of 100 cases, *Canad. M. A. J.* 56:268 (1947).
2. Novak, E.: *Textbook of Gynecology*, ed. 2, Baltimore, 1948, p. 510, Williams and Wilkins Co.
3. Sammartino, R. & Gori, R. M.: Embarazo tubario y Endometriosis. *An. Brasil de Ginec.* 17:85 (1944).
4. Marchetti, A. S., Kuder, K. & Kuder, A.: A Clinical Evaluation of Ectopic Pregnancy, *Am. J. Obst. and Gynec.* 52:544 (1946).
5. Dindia, A. J., & Turcotte, V. J.: Extrauterine Pregnancy, *Am. J. Obst. & Gynec.* 52:321 (1946).
6. Whitacre, F. E., Lynn, H. D., and Morrison, D. B.: Spectroscopic Examination of Hematin in the Peripheral Blood, *A. J. Obst. and Gynec.* 55:838 (1948).
7. Nucci, R.: A Ten Year Survey of Ectopic Pregnancy, *Pennsylvania M. J.* 49:953 (1946).
8. MacFarlane, K. T., and Sparling, D. W.: Ectopic Pregnancy: Selected Data from 110 cases, including a Report of Two Unusual Cases. *Am. J. Obst. & Gynec.* 51:343 (1946).
9. Burch, L. E., and Setchik, J.: Ectopic Gestation: Diagnostic Value of Cul-de-sac Puncture, *Am. J. Obst. & Gynec.* 50:765 (1945).
10. Bunde, C. A.: Evaluation of Pregnancy Tests by Ovarian Hyperemia in Immature Rats. *Am. J. Obst. & Gynec.* 53:317 (1947).
11. Beacham, W. D., Collins, C. G., Thomas, E. P., & Beacham, D. W.: Ectopic Pregnancy. *J.A.M.A.* 136:365 (1948).
12. Williams, P. F., and Corbit, J. D.: An Analysis of 101 Fatalities from Ectopic Pregnancy. *Am. J. Obst. & Gynec.* 48:841 (1944).

Histoplasmin Sensitivity in Columbia, South Carolina

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AND

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Histoplasmosis has been considered a rare, uniformly fatal disease. Only 74 cases had been reported by January, 1945 and at the present time, the total number of cases reported is less than 100.¹

That a benign form of histoplasmosis exists, is suggested by studies of Christie and Peterson.² They were impressed by the large number of calcified Pulmonary lesions which could not be explained on the basis of tuberculosis. Their patients were residents of Tennessee.

It is well known that chronic necrotizing infections, such as tuberculosis, commonly cause pulmonary calcification. In fact, this disease is strongly suggested whenever these deposits are found. As long as the tuberculin skin test was the principal method used for screening large population groups, there was little room to question the etiology of the opaque shadows seen in chest plates of tuberculin positive individuals. When it became practical to employ x-rays in addition to the skin test, a surprising discrepancy was noted between the incidence of pulmonary calcification and positive tuberculin tests.

There has been developed an antigen from a culture of *Histoplasma capsulatum*, this antigen to be used as a skin test and given the name of "Histoplasmin."

Palmer³ tested over 3,000 student nurses in widely separated areas and found that 23% were positive to Histoplasmin. The percentage varied considerably in different cities. Minneapolis and St. Paul had the fewest with 5%. Philadelphia was next with 12%. Detroit had 14%. Kansas City, Kansas and Kansas City, Missouri were the highest with 50% and 62% respectively.

Over 17,000 persons in Kansas City, Missouri were examined by Furcolow, High and Allen, with Histoplasmin, tuberculin tests and chest x-rays.⁴ These findings were essentially the same as Christie's and Peterson's. The incidence of pulmonary calcification was over twice as much among reactors to histoplasmin as among those reacting to tuberculin.

Waring and Gregg of Charleston, South Carolina have reported on 121 cases of histoplasmin intradermal tests carried out on white children in an orphan asylum and found an incidence of sensitivity to histoplasmin less than 2%. These are the only reported figures on record from South Carolina.

In Richland County Tuberculosis Clinic, with the aid of the Richland County Health nurses, we have carried out 1,000 histoplasmin intra-dermal tests. These patients received a tuberculin test, also chest x-rays 14x17 or 70 m.m.

The histoplasmin antigen was obtained from U.S.P.H.S. Medical Mycology Laboratory, Duke University School of Medicine, Lot #H-40.

The technique of performing the test is similar to the Mantoux test. 0.1 ml. of a 1:1000 dilution is given intradermally on the volar surface of the forearm. The reading is made at the end of 48 hours. A reaction of 5mm. or more of induration is considered positive. A reaction less than this is recorded as doubtful and those are repeated. Care must be taken with syringes to prevent cross reaction with other antigens or materials that may have been previously used in the syringes.

In the Richland County Health Clinic, starting June 1st, 1948, all persons going through the clinic were asked whether they were willing to have the histoplasmin test given to them. Explanation was given to each person as to why the tests were given.

Table No. 1

HIISTOPLASMIN REACTORS ACCORDING TO AGE

Race	No. Tested	Number Reactors Histoplasmin	Percentage Reactors
White	514	24	4.6
Colored	486	15	3+
Total	1000	39	3.9

Out of the 1,000 tested there were 514 white patients given the test with 4.6% positive reactors,—486 colored patients with 3+ positive reactors. There were about 1.5% more reactors in the whites than the colored. Total of white and colored was 3.9% positive reactors.

Table No. 2 demonstrates the positive reactors in regard to sex. There were 514 males in this series with 4.6% positive. 486 females with 3+ positive reactors. There were about 1.5% more reactors in the whites than the colored. Total of white and colored was 3.9% positive reactors.

Histoplasmin reactors as to age is shown in Table No. 3. The ages were broken down into age groups 1-5, 6-10, 11-20, 20 and over. There were 21 tests given in the first age group 1-5 with no positive reactors; Second group 6-10 had 76 tests with 1 re-

Table No. 2
HISTOPLASMIN REACTORS
ACCORDING TO SEX

Sex	Number Tested	Number Reactors Histo-plasmin	Percentage Reactors
Male	514	24	4.6
Female	486	15	3.4
Total	1000	39	3.9

actor; 11-20 age group with 465 tested showed 1.5% positive reactors; 20 plus age group 438 were tested with 7% positive reactors. Here in Richland County the older the person, the greater percent of positive histoplasmin reactors.

Table No. 3
HISTOPLASMIN REACTORS
ACCORDING TO AGE

Age	Number Tested	Number Reactors	Percentage Reactors
1-5	21	0	--
6-10	76	1	1.3
11-20	465	7	1.5
21-over	438	31	7
Total	1000	39	3.9

Each patient received a tuberculin test and also an x-ray of the chest. Table No. 4 gives the positive histoplasmin and positive tuberculin reactors. There were 39 positive histoplasmin reactors and 413 positive tuberculin reactors. Thirty patients were positive to both histoplasmin and tuberculin. Pulmonary calcification was present in 13 of the 39 positive histoplasmin. This is 33% of the patients with calcification positive to histoplasmin. Pulmonary calcification of the positive

tuberculin was only 2.4%.

*Of the 39 positive reactors to histoplasmin, 18 lived only in South Carolina, 19 had lived in other parts of the country, and 2 not accounted for.

Histoplasmin and tuberculin reactors are shown in Table No. 5. There were 196 white positive tuberculin tests with a percentage of 38. There were 217 colored positive tuberculin tests with a percentage of 45%. The total white and colored tuberculin positive tests were 41.3%. This figure is in line with the decline in death rates of pulmonary tuberculosis in Richland County.

In order for pulmonary calcification to be produced by histoplasmosis capsulatum there must be a benign pathological process in the lungs. This infectious process must go through an acute stage and then into the calcium stage for the calcium deposits to be placed in the lungs. In view of these facts, it would seem that one should consider histoplasmosis in any case in which there are various combinations of fever, nodular or ulcerative lesions of the skin or mucous membranes, generalized lymphadenopathy, hepatosplenomegaly, anemia and leukopenia, and low blood pressure. A patient with pulmonary diseases resembling tuberculosis but with negative sputum and negative tuberculin tests, one must certainly consider histoplasmosis in the differential diagnosis. This is particularly true in sections of the country where we find a high incidence of positive reactors to the antigen histoplasmin. It goes without saying that one cannot diagnose a disease without thinking of these factors.⁶

Summary:

(1) There were 1,000 patients tested with histoplasmin intra-dermal antigen in Columbia, South Carolina with 3.9% positive reactors.

(2) A study was made as to race, sex and age of the 1,000 cases.

(3) Histoplasmosis should be considered in pulmonary calcification.

TABLE NO. 4
HISTOPLASMIN AND TUBERCULIN REACTORS

No. Tested	Positive Histoplasmin	Positive Tuberculin	Positive Histoplasmin and Positive Tuberculin	Calcification present with Positive Histoplasmin	Pos. Tbc.
1000	39*	413	30	13	10

TABLE No. 5
HISTOPLASMIN AND TUBERCULIN REACTORS ACCORDING TO RACE

Race	No. Tested	Positive Histoplasmin	Percentage Histoplasmin	Positive Tuberculin	Percentage Tuberculin	Tuberculin Negative Histo-plasmin Positive
White	514	24	4.6	196	38	5
Colored	486	15	3.4	217	45	3
Total	1000	39	3.9	413	41.3	8

REFERENCES

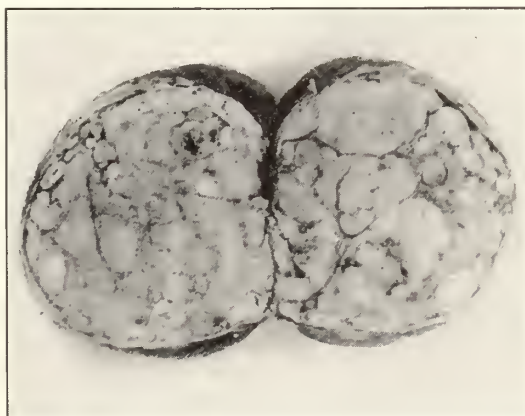
- (1) Ivan L. Bunnell and Michael L. Furcolow: A report on test-proven cases of Histoplasmin. Public Health Report—March 5, 1948, Nov. 10.—Page 229.
- (2) A. Christie and J. C. Peterson: Pulmonary Calcification in negative Reactors to Tuberculin. American Journal of Public Health, 35:1131, 1945.
- (3) C. E. Palmer: Non-Tuberculous Pulmonary Calcification and Sensitivity to Histoplasmin. Public Health Rep., 6:475, 1946.
- (4) M. L. Furcolow, R. H. High, M. F. Allen: Some Epidemiological Aspects of Sensitivity to Histoplasmin and Tuberculin. Public Health Rep. 61:1132, 1946.
- (5) J. T. Waring, and D. B. Gregg: Pulmonary Calcification and Sensitivity to Histoplasmin in Charleston, South Carolina. American Journal of Diseases of Children. February, 1947.
- (6) Hollis E. Johnson and Randolph Batson: Benign Pulmonary Histoplasmin. Diseases of the Chest, 4: 525, 1948.

Wilms Tumor—A Report of a Six Year Postoperative Cure

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Wilms tumor is the most common tumor seen in young children, especially before the age of three years.¹ It is a very fatal neoplasm. It has been estimated that the overall mortality is 90 per cent or more, even with the best treatment. Ladd and Gross⁷ show a slightly less mortality rate in their operated series. Because of the tendency to rapid local invasion of adjacent tissues by tumor cells, early operation is advised and even then, complete removal of all the tumor is frequently impossible. In about one-third of those who apply for treatment, the tumor is no longer operable and in approximately 40 per cent of those, in whom the tumor appeared to have been removed, a recurrence takes place within the usual "five year cure" period. Ladd and Gross have stated that because of its high degree of malignancy, failure to completely remove the tumor is most often apparent within six months after operation and the usually accepted five year cure rule should not be required.

Various theories of histogenesis of Wilms' embryonal adenomyosarcoma have been postulated since its first description by Eberth³ in 1828. Perhaps the most likely explanation is that of Ewing,⁴ who stated that the tumor arises in the renal blastema and by metaplasia the various types of tissue cells found in the tumor are derived. Weisel, Dockerty and Priestly⁸ have described Wilms' tumor as being well encapsulated, with a composition grossly suggesting sarcoma, of a gray white color and having blood filled cystic spaces associated with multiple scattered areas of fatty



Gross appearances of left kidney containing tumor growth measuring 10 x 8 x 8 cm.

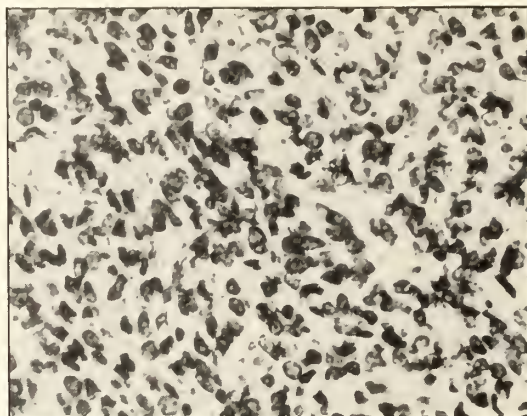
necrosis. This appearance is best demonstrated on the freshly cut surface of the tumor. They also feel that to correctly classify a neoplasm of the renal area as a Wilms' tumor, the tissue, microscopically, should contain a combination of carcinoma-like cells in tubular, cylindroid, papillary or medullary arrangement, plus other spindle shaped sarcomatoid cells. Smooth and striated muscle fibers are not uncommon in these tumors and in rare cases cartilage and bone cells are found. The formation of these latter cells is interpreted as a perversion of growth on the part of the embryonal mesenchymal cells.

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Wilms' tumor usually begins in the renal cortex and, by growth, compresses and destroys the whole kidney and then spreads to neighboring organs. Distant spread by blood stream and by lymphatics has been disputed



Microscopic appearance of kidney being infiltrated with tumor cells.



Microscopic high power appearance of tumor showing many mitotic figures scattered among small cells and small spindle shaped cells composing a large portion of the tumor tissue.

but the presence of metastatic areas in the lungs is frequently recorded in advanced cases. Recently, Ferris and Beare⁵ reported a case of postoperative recurrence of a Wilms' tumor in the bladder mucosa. By the usual method of metastasis this would be anatomically impossible so that it appears the tumor cells can spread as a transplant via the urinary flow. Characteristically, Wilms' tumor cells are extremely radio-sensitive. Their rapid response to radiation therapy has often been used as a diagnostic, as well as a therapeutic measure.

The symptomatology of Wilms' tumor is frequently nil.² The first sign is the accidental discovery of a rounded tumor in a young child's abdomen. Occasionally the child has been fretful, had bouts of fever or appeared pale, but symptoms referable to the urinary tract are exceptional. Hematuria, as reported by Weisle, Dockerty and Priestly⁶ in five of forty-five cases is out of the ordinary because only late in its course does the tumor invade the renal pelvis. No difference has been shown as the incidence in male or female or to right or left kidney. Occasionally it has been found bilateral.

A typical case to be presented is considered worthy of report because approximately six years have passed since operation, during which time repeated examinations have not revealed evidence of further existence of the tumor. No radiation therapy was administered either pre or postoperatively. The child's growth and development has paralleled that of the normal boy of the same age.

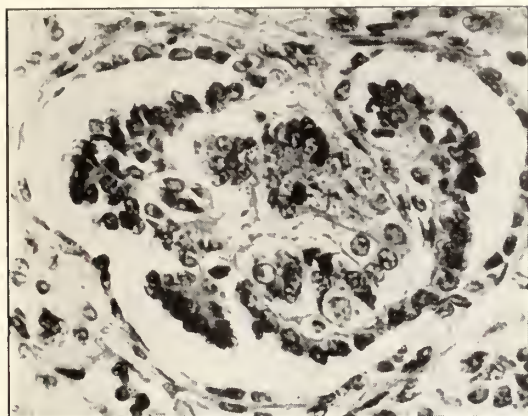
Report of Case. T. S., Hospital No. 2605. A boy 11 months of age was admitted to Marion Sims Memorial Hospital on March 6, 1942. A mass in the upper left abdomen had been noted three weeks previously. This mass was estimated to have increased 25 per cent in size between the date of its first appearance and the day of admission to the hospital. The child was a full term, normally delivered infant which developed, without illness, to weigh twenty-four pounds at eleven

months of age. Physical examination revealed no abnormality except for the presence of an oval, smooth mass which filled the left half of the abdomen, extending from beneath the left costal margin to the left iliac crest. X-ray examination of the chest showed no evidence of pulmonary pathology and that the heart was normal in position and size. Fluoroscopy of the abdomen revealed the mass which appeared to be the left kidney. Results of laboratory determinations were: RBC 3,450,000; hemoglobin 65%; WBC 9,200, of which neutrophils were 40%, lymphocytes 48%, eosinophils 1% and monocytes 11%. A Kahn test was negative. The urine was acid, negative for albumen; a trace of sugar and trace of acetone were present, but no diacetic acid. No formed elements were found in the centrifuged specimen.

It seemed advisable that operation be performed without delay for removal of the left kidney tumor. The day after admission, under open drop ether anesthesia through a "T" shaped incision, a transperitoneal left nephrectomy was performed after reflecting the descending colon medially and exposing the renal pedicle. The renal vein, artery and ureter were separately ligated and sectioned as far from the renal pelvis as was possible. No gross evidence of extension of the tumor beyond the kidney proper was noted. A single drain was inserted into the retroperitoneal space through a stab wound and the abdomen closed in layers after suturing the descending colon in its former position. A whole blood transfusion of 150 cc was given at the end of the operation. The patient's postoperative course was entirely uneventful and he was dismissed from the hospital on the seventh postoperative day.

The pathologic report as described by Dr. Paul Kimmelstiel is as follows:

Macroscopic description: The specimen measures 10 x 8 x 8 cm. The surface is smooth. A longitudinal section reveals a large tumor in the peripelvic tissue



Incomplete glomerular anlagen seen scattered throughout the tumor tissue.



Photograph of patient six years after treatment showing the type of incision used to remove the left kidney in this instance.

which on cross section is white, rather structureless, and moist on the cut surface, and which compresses the pelvis and kidney in such a fashion that the kidney tissue forms narrow shell almost all around the tumor, with the exception of the hilar region, where the tumor is covered by pelvis. At its thickest portion, which is at the upper pole, the kidney tissue measures 0.8 cm. in thickness. On opening the vessels and pelvis no tumor can be found.

Microscopic description: Several histologic sections are taken which show essentially the same picture throughout. The tumor cells are arranged in rather small lobules separated by moderately cellular connective tissue, which contains occasional tubules lined by cuboidal epithelial cells. The interstitial tissue in areas is rather edematous. The tumor lobules proper consist of a mixture of small round cells and short spindle shaped elements, blending imperceptibly into a system of bizarre shaped tubules lined by high cuboidal epithelial cells. There are furthermore numerous small incomplete glomerular anlagen, characterized by papillary projections of the above mentioned epithelial cells into a spherical space. The tumor is extremely cellular, and there is much variation in shape, size and staining effect. Numerous mitotic figures are encountered.

SUMMARY:

1. Wilm's tumor is described as a pathologic entity.
2. A case report of Wilm's tumor, treated surgically with a six year apparent cure is given.

*Footnote: The author wishes to express his appreciation to Dr. Paul Kimmelstiel of Charlotte, North Carolina, for the detailed pathologic study and photographs of this Wilm's tumor.

BIBLIOGRAPHY

1. Boyd, William: Textbook of Pathology. Lea and Febiger, Philadelphia, Page 646, 1947.
2. Dodson, A. T.: Urologic Surgery. The C. V. Mosley Company, St. Louis, Pages 324-333, 1944.
3. Eberth, C. J.: Cited by Ferris, Deward O. and Beare, John B. Wilm's Tumor, Vide Infra No. 5.
4. Ewing, James: Neoplastic disease, A Treatise on Tumors. Ed. 4, Philadelphia, W. B. Saunders Company, Pages 1160-1940.
5. Ferris, Deward O. and Beare, John B.: Wilm's Tumor, Report of Case with Unusual Postoperative Metastasis. Proceedings of Staff Meetings of the Mayo Clinic, Vol. 22, No. 5, Pages 94-98, March 5, 1947.
7. Ladd, William E. and Gross, Robert E., Abdominal Surgery of Infancy and Children, Philadelphia, W. B. Saunders Company, Pages 411-426, 1947.
8. Weisel, W. Dockerty, M. B. and Priestly, J. T.: Wilm's Tumor of Kidney; Clinical Pathologic Study of 44 Proved Cases. J. Urology 50:399-413. October, 1943.

Objectives of a State Committee on Maternal Mortality

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One hundred and forty-nine women died in South Carolina last year because of conditions associated with pregnancy or labor. The resulting mortality rate per 1000 live births was 2.5. These figures have resulted from consistently downward trends in maternal mortality which began 12 years ago, in 1936, when there occurred 295 deaths, a rate of 7.7 per 1000 live births. (Table 1). This Table shows the number of deaths and the rates per year and breaks down the totals into figures for white and colored women. Note that the total number of deaths for colored women ranges from 1½ to twice that for white women, while the rate for colored women ranges from slightly more than that of the whites to something over twice the white rate.

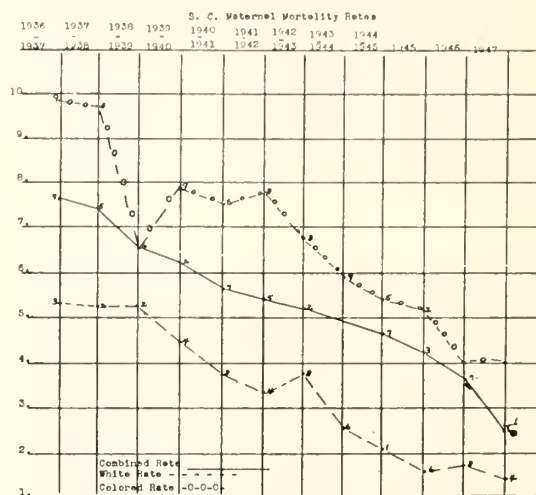
TABLE 1

	Maternal Deaths			Rates per 1000 live births		
	Number	White	Colored	Rates	White	Colored
1936-37	295	99	196	7.7	5.3	9.9
1937-38	302	101	201	7.5	5.2	9.8
1938-39	264	102	162	6.6	5.2	6.2
1939-40	263	93	170	6.2	4.4	7.9
1940-41	253	86	167	5.7	3.8	7.6
1941-42	266	83	183	5.5	3.4	7.8
1942-43	256	104	152	5.2	3.9	6.8
1943-44	201	70	201	4.1	2.6	5.9
1944-45	190	58	132	3.7	2.1	5.5
1945	165	44	121	3.3	1.6	4.0
1946	146	54	92	2.7	1.8	4.0
1947	149	48	101	2.5	1.4	4.0

Chart 1 shows this graphically. No attempt has been made to explain why the colored rate fell in 1938-39 from 9.8, the rate of the year before, to 6.6, and rose again the next year to 7.9. It is interesting to note that the difference between the white and the colored rates per 1000 live births has fallen from about 4½ to 2½. In other words, the rate has fallen more rapidly for the negroes than it has for the whites, and both rate curves for the last two years have tended to flatten out.

There may be several factors to help explain the rapid fall in the mortality rate curves. The more obvious were a natural result of the generally better economic condition of our people. This allowed for better nutrition, earlier and more frequent calls for

*Read before the members of the Obstetric Seminar, University of Georgia School of Medicine, Augusta.



medical assistance, and an increased relative number of hospital admissions for treatment of complications of pregnancy and for delivery. But I believe that these factors as important as they are, are not the basic ones, but that they were activated by other factors not dependent upon the economic situation. They were the direct result, I believe, of a planned and extensive educational program.

In 1935 a committee on Maternal Welfare of the South Carolina Medical Association was first appointed. This committee, headed by Dr. Robert E. Seibels continued to function for seven years, that is until June, 1941, when it was not reappointed.

The work of this committee during the first year of its operation was largely a statistical and analytical study of the various factors which were involved in each of the 384 maternal deaths which occurred that year. The task was difficult. Quoting from the report:

"Not only are deaths thus erroneously classified as is shown above, but there is every reason to believe that many maternal deaths occur that are incorrectly assigned to nonpuerperal causes . . . The Committee is impressed with the carelessness exhibited in reporting the cause of death and the inadequacy of the information given."

The report made several recommendations which were based on that first year's study. It requested that physicians exercise greater care in filling out death certificates and in filing birth certificates. It urged

them to require their pregnancy patients to see their doctors more frequently and it asked the doctors to keep records of their findings at each visit. It recommended refresher courses for physicians, and more training for midwives, and it urged recognition of the seriousness of obstetrical emergencies, and warned that care should be exercised in not making such emergency conditions more serious by illadvised treatment measures.

The committee further recommended to the Division of Maternal and Child Health of the State Board of Health that prenatal care be offered to the women of the State through that department.

By means of this first years work, the committee had launched into a program, not only of statistical study, but it had already begun a program of education and suggestion directed to the doctors as individuals and as a group, to the public health workers and to the laity as well.

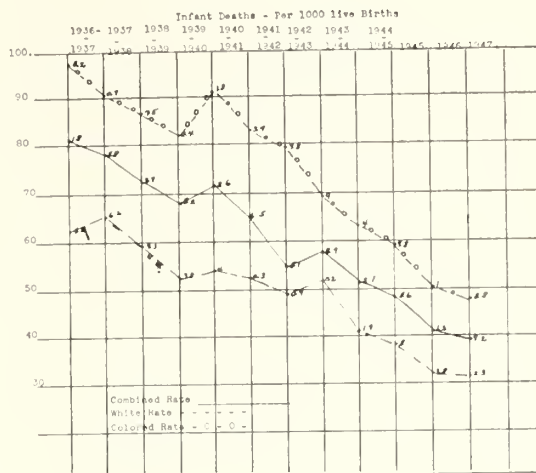
In its next year's report, the committee stated:

"The major problem of reduction of maternal mortality continues to be a rural one and probably will be for many years to come. No hope of greatly changing the high rate can be entertained except through the taking of adequate prenatal care to the patient and by some system of community nursing, bringing to these isolated homes both physicians and material for adequate delivery care. This (lack of prenatal care) cannot be denied as the principal factor leading to a fatal outcome and especially in cases of hemorrhages, sepsis and kidney failure. . . . We cannot too strongly urge the extension of medical service in those counties where hospitals exist and the addition thereto of a well organized and carefully supervised out-patient delivery service."

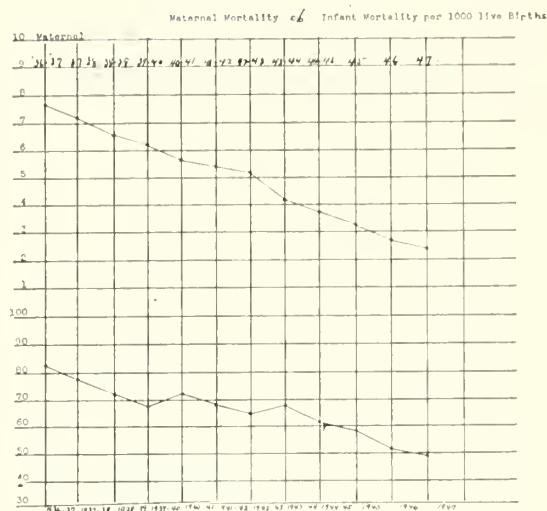
The report then states that there was evidence of better record keeping on the part of the physicians and adds: "The recording and analysis of disasters in obstetrics is bound to make the physician doing so take serious thought as to the method he employs."

The next year the committee reported a reduction of 20 per cent in the number of maternal deaths and stated, "In the last analysis, we must turn to the general practitioner who works in the smaller communities. . . . Since we accused him in a large measure for being responsible for the high mortality, we must now recognize the fact that his cooperation, willingness to listen to reason, devotion to duty and thoughtful consideration of his patients has indeed accomplished the bulk of the reduction which has taken place."

Already Public Health clinics had been established for the indigent, but there were not enough of them. The newer knowledge regarding the importance of proper diet in pregnancy was called to the attention of doctors and public health workers, and they in turn carried the teaching to the people. The educational



work initiated and stimulated by the committee was spreading and was bearing fruit. Special obstetrical meetings were held in many of the county societies and obstetrical talks were made by members of this committee or by other speakers to various groups of women throughout the state. A member of the committee edited a question and answer department in the State Medical Journal. Dr. L. A. Wilson, professor of obstetrics at our medical school, was made a full time teacher, and during the summer he conducted obstetrical seminars in each county of the State. Educational motion picture films were shown at these meetings and to other medical groups. A series of popular educational broadcasts were prepared and put on the air. Obstetrical packages were designed and made available at small cost. Child spacing in the interest of health was given study and means were provided to furnish information and needed equipment to those who required such care. The educational program continued to advance, from the committee to agencies and groups and then further and further by formal instruction or by contact and conversation. The indigent went more willingly to free clinics, and pay patients appeared earlier and more regularly at doctors' offices. In 1939 approximately 10,000 prenatal patients registered and came under supervision of the public health (M. C. II.) prenatal clinic. Abnormal cases were referred to practitioners for treatment. Furthermore, it had become very obvious that in general the quality of obstetrical care rendered private patients had undergone a vast improvement and that there had been a marked reduction in deaths among patients in higher income groups. The committee concluded that this was the product of the many educational efforts that were made by all agencies concerned with maternal welfare. However, the statistical and analytical studies made by the committee, with the aid of the bureau of vital statistics, the county health nurses, and the reporting doctors, was the initial stimulus. These studies by the committee sought out and found the causes of the high death rate. Doctors, and public health workers sought to eradicate them.



Although studies of infant mortality does not come strictly under the province of a committee on maternal welfare, still maternal and infant mortality are closely related both actually and statistically as is shown in Charts 3 and 4. Accompanying the fall in maternal mortality there has been a parallel fall in infant mortality in South Carolina during the past 12 years. It is believed that the same factors were operative in the decreased infant mortality that were operative in that of maternal mortality together with the important additional fact that healthy expectant mothers yield as a rule strong robust children.

Table 2 lists the causes of deaths in 1947-48 in their order of incidence. The some old triad, toxemias, infection and hemorrhages heads the list year after year. Infection used to come first. Antibiotics has caused it to yield to one of the other two. Hemorrhages sometimes leads, as it should, perhaps, regularly. Toxemias are in the main preventable or curative if recognized early. That they lead the list in 1947-48 suggests renewed carelessness or ignorance on the part of the women concerned or of their doctors. There has appeared a new group of mothers, since our State committee ceased to exist in June, 1941, and there are many new doctors, back from the war, who have had little obstetrical training. They have had experience in treating hemorrhage and shock. They had not had experience in treating toxemia of pregnancy. Perhaps this explains why nearly one-third of our maternal deaths were caused by toxemia.

This year it appeared to our State Association that it was time to re-establish a committee on maternal welfare. This discussion has been prepared by me, in the capacity of chairman of that committee. The committee has given much thought to its objectives, both immediate and more distant and to methods of attaining those objectives. A study of the reports of the previous committee has seemed to point the way. As did that other committee, so shall we have to ask and

TABLE 2

Number and Causes of Maternal Deaths in S. C. — 1947-48

	White	Colored	Total
Toxemias	17	33	50
Infection	15	13	28
Hemorrhages	6	19	25
Other Diseases and			
Accidents of Pregnancy	11	11	22
Abortions	1	12	13
Ectopic Gestation	4	7	11
Total Deaths	54	95	149

receive the whole hearted cooperation of the doctors, the county health units and the maternal and child health division of the State Board of Health.

Our task shall be to try to determine what deaths might have been prevented, how they could have been prevented and why they were not prevented. This will require rather detailed information from the attending physicians. This we hope to get through the cooperation of the doctors by the use of a rather simple questionnaire form, which will be sent to the doctor, as soon as practical after the death certificate has reached the bureau of vital statistics. These questionnaires will be studied by the entire committee, which is composed of one specialist, the director of the Division of Maternal and Child Health of the State Board of Health, and three family doctors who care for many obstetric cases. The doctor who signed the death certificate and who sends in the questionnaire will be told of the conclusions of the committee and the ease will be briefly discussed in a letter to him. No doubt in many instances he will have already formed opinions similar to those of the committee. Sometimes he may honestly differ with the committee, and sometimes he may be reminded of some forgotten or overlooked fact or procedure which if used might have altered the outcome. To such an extent the study and report will be educational.

The committee is requesting that every county society set aside one meeting each year for obstetrical discussion. If requested, the committee will provide a speaker and will arrange a program. The South Carolina Obstetrical and Gynecological Society is co-operating in this latter effort. Through the leadership of Dr. Manly E. Hutchinson, its president, there has been organized a speakers bureau from its roster of members, and this bureau offers its services to any group desiring a talk on obstetrics or gynecology. In so far as it is practical, the speaker sent, will come from beyond the territory in which the meeting will be held. By this practice, any charge of self-advertising by the speaker will be eliminated.

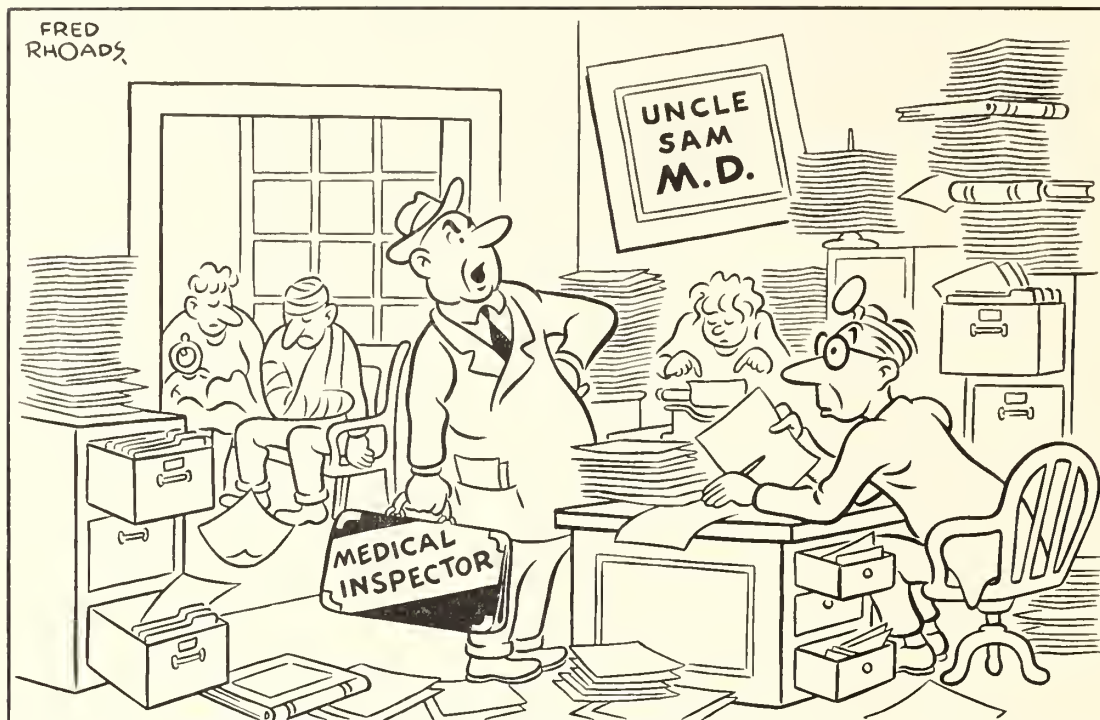
The committee will seek to publicize its desire to cooperate with various lay organizations which might

desire to have an obstetrical program, by occasional releases to daily and weekly newspapers throughout the state. These releases will seek to be educational as well as offering to secure speakers.

Just as did Dr. Seibels' committee, the present committee has found that hospital charts are frequently inadequately, incompletely and carelessly written up. The committee feels that careless recording goes hand in hand with careless thinking and practice. It will make an effort to improve this situation.

Most hospitals require special qualifications before a doctor is allowed to do major surgery. Such a requirement is not and should not be made in the case of a doctor doing obstetrics. And yet the opportunities for doing irreparable damage to a trusting patient by a poorly trained or a careless accoucheur are almost as great as they are by a poorly trained or a careless surgeon. Hence it is, that so many hospital staffs have rather rigid rules requiring obstetrical consultation in complicated labors. This is a wise measure, and our committee hopes to be able to extend that practice and

to encourage adherence to its provisions. Formal consultation is educational to both consultant and consultant. The committee has no authority other than that which comes by its relationship to the House of Delegates of the State Association which created it. It can only plead for cooperation, not demand it. It is not selfish, it is not hypercritical, and its criticisms are not unfriendly, but are intended to be helpful in a friendly manner. Its entire activity revolves around extension of obstetrical knowledge to the doctors and their patients. Its work is designed to be educational, stimulative, and helpful. It will not seek to be a policeman, but it will be a sympathetic friend, looking over your shoulder as you work, ready to give encouragement and helpful suggestions when needed, and seeking to stimulate you to do your best work always. To men such as you, who have left your practices to come here to study for a week, we shall look for cooperation and suggestion, and each of you should serve as a focus for the spread of knowledge in your own community, and as a stimulus to your colleagues to do better work.



"DOCTOR, YOUR WORK IS UNSATISFACTORY. YOU'RE NOT SENDING YOUR RECORDS IN QUINTUPPLICATE."

ABSTRACTS

Lundy, J. S.: *Advances in Anesthesia, Surg.* 24: 995, December 1948

The great latitude in choice of agents and methods has been the most important advance in anesthesiology.

Nitrous oxide is a quick analgesic agent with a short period of recovery and is relatively safe in respect to explosion hazards. While ethylene and cyclopropane are more explosive, their use is widespread, because ethylene is still one of the outstanding agents from the standpoint of safety in patients suffering from shock or heart disease, and cyclopropane is capable of producing better relaxation than any of the other gases. The so-called cyclopropane shock seen at the termination of anesthesia is not fully understood.

Of the several types of ether that have been developed, none seems better than the diethyl ether. Chloroform and ethyl chloride are not in general use today.

In the field of local anesthesia various agents such as nupercaine and pontocaine have been introduced to provide prolonged anesthesia which could not be maintained with a single dose of procaine. Continuous spinal and caudal anesthesia by means of a

catheter instead of a needle makes it possible to produce anesthesia of desired length with procaine, believed by the author to be the safest available agent for local anesthesia.

The introduction of the Magill intratracheal tube has decreased morbidity and mortality rates in major surgery of the abdomen, chest, head, and neck, because it provides more room for the surgeon, an open airway, quieter respiration, less increased intracranial pressure, and permits inflation of the lungs during chest operation, as well as allowing more latitude in the position of the patient. It allows aspiration of material from the bronchial tree during and after anesthesia.

Pentothal sodium is a useful anesthesia when preceded by preliminary sedation and is given in doses of not more than 2 gm. in a 2½% solution. Small quantities of pentothal to induce anesthesia before inhalation anesthesia is much appreciated by patients.

Curare in combination with the various anesthetic agents provides excellent relaxation with relatively little postoperative prostration than heretofore possible.

The anesthesiologist's understanding of the anesthetic agent and the use of stimulants and supportive measures are as important as the type of anesthesia employed.

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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FEBRUARY, 1949

A LETTER OF APPRECIATION

Members of the South Carolina Medical Association

Since the meeting of the American Medical Association in St. Louis, at which I received the General Practitioner Award, I have been anxious to express to you my sincere appreciation of your kindness to me. The officers and members of the South Carolina Medical Association have, indeed, been most gracious in nominating me for this award.

As I stated in St. Louis in accepting the award, I wish now to say to you that I think of this honor, not as that which has come to me personally but rather as a representative of the great company of splendid men who are devoting their lives to the work of the general practitioner. I esteem it a great honor to be numbered among them.

Permit me to assure you that I will steadfastly seek to use the opportunities which this award makes possible for me in furthering what I believe to be the highest and best interests of the South Carolina and the American Medical Associations and also of the multitudes of men and women to whom members of these associations daily minister.

With abiding gratitude to each of you and to the Association as a whole, I remain,

Yours, most sincerely,
W. L. "Buck" Pressly

ANNUAL MEETING

Plans are being completed for our annual meeting this year at Myrtle Beach. The dates—May 17, 18, 19. The place—Ocean Forest Hotel.

The House of Delegates will meet on Tuesday afternoon, May 17, preceded by a meeting of the Council that morning. Social entertainment for all members of the Association and their wives is being planned for that evening. Wednesday morning and afternoon and Thursday morning will be devoted to scientific sessions. The Medical College Alumni luncheon will be held at one p. m., Wednesday and the annual banquet of the Association that evening.

Reservations should be made early and we are assured that those reservations, when affirmed, will be available up to the designated hour.

Every member of the Association is urged to come to the meetings and to stay through the entire evening.

PESSIMISTS

More and more we are struck by the number of pessimists to be found in the medical ranks. Only recently one was overheard saying, "Socialized medicine is the worse thing that could happen to this country—I know that. It would mean passing out pills and prescriptions to everybody instead of practicing decent medicine for those who need it. But there's nothing we can do to prevent its coming. We're beaten and we might as well acknowledge the fact."

To such an individual and to those whose ideas are in line with his, might we suggest that they allow their thoughts to turn back to October, 1948. Expressions of a similar nature were being expressed by Democrats the country over as they looked forward to the coming national election. Pollsters, prognosticators, and gamblers were saying the same thing. Then came November 2.

We may disagree with President Truman in some respects—particularly in his proposal for a system of federal medical care—but we must take off our hats to him as a fighter. He refused to concede defeat and he won.—But he didn't win by doing nothing—he worked.

The fight against socialized medicine is nearing its final stage. It can be lost if we throw in the towel now. It can be won if every physician who knows that it is not for the best interests of the country, rolls up his sleeves and gets to work. The trend of the times and the propaganda of the socialists have placed doctors of medicine in an inenviable—but not a hopeless—condition. Of this we are convinced.

The greatest foe which every physician has in his daily fight against poor health is ignorance. The same is true in his fight against socialized medicine. The man on the street has been told so many times that the panacea for all human ailments is the payment of a medical bill by Santa Claus, that he is beginning to believe that it is true. Let him learn that such is far from the truth and his thinking will change.

John Doe put up with an O. P. A. in time of war but he does not want it in times of peace. Why then

should he want an O. M. A. (Office of Medical Administration) which would attempt to ration medical services in place of gasoline and sugar.

The man in the street is still a thinking man and his mind is open to reason and his ideas to change—if the facts are presented to him in an understandable way. And who can better tell him the facts of life than his own physician.

Think this over, you pessimists, then unlimber your biggest guns and get into the fight.

GREENVILLE — MARLBORO

Greenville County was the first county to send in a substantial number of \$25.00 contributions to the American Medical Association. To Marlboro County goes the honor of being the first county to send in \$25.00 from each of its members. To these two societies we offer our sincere congratulations and hope that their example will be an inspiration to the other county medical societies in the state.

ALUMNI POST GRADUATE SEMINAR

Plans are well under way for the eighth annual Alumni Post Graduate Seminar. At a meeting in Columbia on January 8, the officers, directors, councilors and post graduate committee discussed results of the postcard questionnaire recently sent out by the secretary and made several changes which it is believed will make the program more attractive to the practitioners of the state, and also make it possible for more of them to attend it.

The changes include shortening the program a day and a half, substituting more speakers for the clinical case presentations and round table discussions, and including two speakers from the Medical College faculty. The tentative program adopted by the faculty seminar committee at a meeting on January 13 is as follows:

Wednesday evening, November 2: Reserved for class, fraternity and other informal parties.

Thursday, November 3:

9:15 A. M. Welcoming Speech.

Announcements.

9:30 A. M. Faculty Speaker.

10:00 A. M. Internist.

11:00 A. M. Surgeon.

12:00 Noon Obstetrician.

1:00 P. M. Medical College Luncheon.

2:30 P. M. Pediatrician.

3:30 P. M. Internist.

Evening: Founders' Day Banquet.

Friday, November 4:

9:00 A. M. Faculty Speaker.

10:00 A. M. Gynecologist.

11:00 A. M. Surgeon.

12:00 Noon Internist.

ENRICHMENT OF CORN MEAL AND GRITS

The diets of many people in South Carolina contain corn meal and grits every day. Some eat more meal and grits than flour because they like corn foods better, others eat large amounts of corn foods because they are least expensive. The enrichment of flour is nationwide and twenty-three of the states have laws requiring enrichment of flour and bread. The enrichment of corn meal is not yet south-wide but leading nutritionists would like to see all corn meal enriched. Degerminated corn meal and grits are required by laws of five southern states to be enriched, but the corn meal ground in local mills is exempt on the basis of being a whole grain product.

The fundamental reason for adding vitamins and minerals to flour, meal, and grits is to help correct a deficiency in the human diet rather than merely change the chemical composition of a foodstuff. When South Carolina enacted its degerminated corn enrichment law it was realized that it would be desirable to enrich all corn meal and all grits so that these foods would contain as much vitamins and minerals as enriched white flour but conditions in 1943 made it advisable to exclude locally produced whole corn meal and grits from the legislative proposals. The State Nutrition Committee rightly took the position that the degremented products were impoverished in the milling process and needed enrichment most. Furthermore, degermed products were produced in large mills that could enrich large tonnages with little equipment and little manpower.

In the last five years considerable data has been published showing that niacin can be partially replaced by the amino acid tryptophane. Analyses of whole ground corn show that it is especially low in both niacin and tryptophane. This threw some light on why inclusion of high levels of corn in the rations of dogs brought on black tongue quicker than an equal weight of dextrinized starch. Analyses showed milk to also be low in niacin but unlike corn, it was high in tryptophane which explains its ability to prevent the niacin deficiency in dogs known as black tongue. Research with rats confirmed the chemical analyses and findings with dogs that corn was unusually low in the pellagra preventives; niacin and tryptophane. The work with rats also showed that corn required unusually large amounts of niacin from other foods for its complete utilization and prevention of "rat pellagra." These recently discovered facts therefore add to the very sound scientific basis for the corn enrichment program.

Clemson College has taken the enrichment program to the outlying corn mills through its Extension Service and as a result 300 mills in South Carolina are now voluntarily enriching whole corn meal. The Alabama Extension Service has also encouraged some 300 corn mills in that state to begin enrichment. The program has the endorsement of the American Medical Association, the Food and Nutrition Board of the National Research Council and all other organizations that have considered it.

The South Carolina State Nutrition Committee endorsed the idea of amending the law so as to require the enrichment of all types of corn meal sold. The leading millers in the state are now enriching and are in favor of such an amendment as it would even their competition insofar as enrichment is concerned and prevent meal from out of the state being shipped in unless it is enriched. We know that many people

would benefit by a greater intake of the enrichment ingredients which are niacin, thiamine, riboflavin, iron and calcium. We do not know of anyone that has justification to oppose the amendment. The inexpensiveness of the process and availability of the simple feeder that automatically enriches the meal seems to satisfy the corn miller.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

COUNCIL APPROVES PREPAYMENT PLAN

At a special meeting of Council on Sunday afternoon, January 16th, the report and recommendations of the Committee on Medical Service, Dr. J. D. Guess, Chairman, were considered and adopted. The Committee recommended immediate steps to obtain the charter and proceed with the organization of a prepayment plan to be known as The South Carolina Surgical and Obstetrical Prepayment Plan. The proposed organization would provide coverage on a service and indemnity basis, that on the service basis to be available only to subscribers and members of their families having total family incomes not exceeding \$3,500 per year.

The affairs of the Corporation will be managed by a Board of Directors of fifteen, including not less than eight physician-members, chosen from the South Carolina Medical Association. The entire Board, including the physicians and the members of the lay public, will be elected by the House of Delegates upon nomination by the Council of the South Carolina Medical Association.

In order to provide for the participation by members of the Association in the Plan, a fee schedule covering all types of surgery and obstetrical services will have to be established, and the Council agreed that this matter should be determined ultimately by the House of Delegates. At the meeting on January 16th, a committee was appointed by Council, including members representing general practice and the various specialties, to study the matter and draw up a tentative fee schedule for recommendation to the members of the Association. Members of this committee, which has already begun its work, and the branches they represent, are as follows: Dr. J. D. Guess, Greenville, Chairman—Obstetrics and Gynecology; Dr. J. Howard Stokes, Florence, V.-Chairman—Ophthalmology; Dr. W. Wyman King, Batesburg—General Practice; Dr. C. R. F. Baker, Sumter—Surgery; Dr. A. C. Bozard, Manning—General Practice; Dr. J. A. Siegling, Charleston—Orthopedics; Dr. George D. Johnson, Spartanburg—Pediatrics; and Dr. W. T. Barron, Columbia—Urology.

Other important provisions of the proposed Plan are set forth in the By-laws which are carried in full in

these columns. Members of the Association are urged to give careful consideration to these By-laws and familiarize themselves with their provisions. Any comment or suggestion relative thereto should be addressed to Dr. J. D. Guess, Chairman, 200 E. North St., Greenville, S. C., or to the offices of the Association in Florence.

NEW COMMITTEES IN STATE HOUSE OF REPRESENTATIVES

Under the new rules of the House of Representatives, adopted on the opening day of the 1949 session of the General Assembly of South Carolina, the Committees were consolidated and enlarged. The result is a total of eight committees, with no member of the House a member of more than two.

In this new arrangement, the Committee on Medical Affairs was combined with those on Social Security, Penitentiary, State Hospital, Police Regulations, Military Affairs, and Veterans' Affairs. One of the expressed purposes of the new committee organization is to prevent delays resulting from conflicts in the meetings of two or more committees with several men the members of both.

The new consolidated and enlarged committee which will handle Medical Affairs, is the Committee on Military and Public Affairs with 27 members, as follows:

Spivey, Bayliss, Chairman
Conway, S. C.
Easterlin, Francis M., 1st V.-Chm.
Spartanburg, S. C.
Moore, Robert E., 2nd V.-Chm.
Lockhart, S. C.
Taylor, John R., Secretary
Lancaster, S. C.
Blease, T. W., Saluda, S. C.
Bryan, Werber, Sumter, S. C.
Buyck, David D., St. Matthews, S. C.
Cartwright, A. Y., Jr., York, S. C.
Clements, Joseph B., Jr., Florence, S. C.
Culbertson, Charles B., Laurens, S. C.
Culbertson, John Bolt, Greenville, S. C.
Dowling, G. G., Beaufort, S. C.
Eppes, Frank, Greenville, S. C.

Galloway, Robert S., Due West, S. C.
 Goldberg, William Crosland, Bennettsville, S. C.
 Hamilton, Thomas B., Chester, S. C.
 Hinnant, A. Ray, Columbia, S. C.
 Hollings, Ernest F., Charleston, S. C.
 Kelly, Ezell, Camden, S. C.
 Linchouse, C. Walker, Orangeburg, S. C.
 Lampkin, Alva M., Columbia, S. C.
 MacBay, Lloyd W., Charleston, S. C.
 McChesney, Paul S., Jr., Reidville, S. C.
 Pope, Thomas H., Newberry, S. C.
 Richardson, Don V., Georgetown, S. C.
 Smoak, I. A., Walterboro, S. C.
 Welborn, Charles, Anderson, S. C.

REPORT OF SOUTH CAROLINA STATE BOARD OF NATUROPATHIC EXAMINERS

To the General Assembly of the State of South Carolina:

Pursuant to a Concurrent Resolution passed by your honorable body, during its 1948 Session, the South Carolina State Board of Naturopathic Examiners wishes to make the following report of its actions:

This Board mimeographed the Concurrent Resolution, a copy of which is attached hereto and marked Exhibit A, and in April, 1948, sent a copy of the Concurrent Resolution, together with a letter, to each individual who had ever received a license to practice Naturopathy in South Carolina. This was sent by registered mail, return receipt requested. A copy of this letter is attached hereto and marked Exhibit B. The Board also enclosed a copy of an Application for examination with each of these letters.

Thereafter, a letter was sent to every licensee who secured his license from this Board by reciprocity from Tennessee, advising him that this Board would meet on the 11th of August, 1948, at 10 a. m. to determine whether the license previously issued him by reciprocity from Tennessee should not be revoked. A copy of this letter is attached hereto and marked Exhibit C.

The Board in taking this action was governed by the case of Davis et. al. vs. Beeler, Attorney General et. al., 185 Tennessee 638; 207 S.W. 2nd 343, decided by the Supreme Court for the State of Tennessee on the 29th day of November, 1947, and rehearing denied January 16, 1948, and Supreme Court of the United States denied a writ of certiorari. This case reveals that, after an investigation which was conducted in the State of Tennessee, the Legislature revoked the enabling statute which allowed naturopathic physicians to practice in that State, and the above case was instituted by naturopathic physicians in that State to determine the validity of the statute revoking their permission to practice. This Board, feeling that since the State which allowed these practitioners to come into this State had revoked their licenses, their privilege to practice in this State was not greater than their

privilege to practice in Tennessee.

The Board reports that forty-nine received this notice and that out of the forty-nine, eight appeared before the Board. Forty-seven of the forty-nine were revoked and forty-one were given the opportunity of taking the examination before the Board which was to be held in Columbia on November 8, 1948. Of this number, seven took the examination and passed. They were issued licenses, not by reciprocity but by examination. Therefore, forty licenses were revoked which had previously been issued upon reciprocity from Tennessee. Two are being held pending hearing at the request of attorneys for these practitioners. Out of the forty that were revoked, one brought a writ of certiorari in the Court of Common Pleas for Sumter County which matter is still pending in the Court. Subsequently, a letter was written to those individuals who failed to comply with the first letter written to them (See Exhibit B), advising them that their licenses would be revoked and that the Board would meet on the 8th day of September, 1948, at Columbia, S. C. A copy of this letter is attached hereto and marked Exhibit D. As a result thereof, this Board revoked twenty-four licenses, making a total of sixty-four licenses revoked by this Board.

The Board further reports that sixteen of the original letters, Exhibit B, were returned unclaimed. These licenses will be revoked automatically during the current year for failure to renew licenses. There were twenty-one persons who have since died and, of course, these licenses are of no more effect.

The Board has now pending before it a case in which a practitioner is being required to show cause why his license should not be revoked, which very probably go through the Courts. Therefore, there are two actions pending which are now, and will be, in the Courts.

Recommendations

The Board would respectfully call the attention of the General Assembly to the fact that the Concurrent Resolution does not have the force and effect of law and the Board met this impasse in the first case brought in Sumter, above referred to.

(a) It would, therefore, recommend a Joint Resolution revoking all licenses heretofore issued by this Board upon reciprocity from the State of Tennessee.

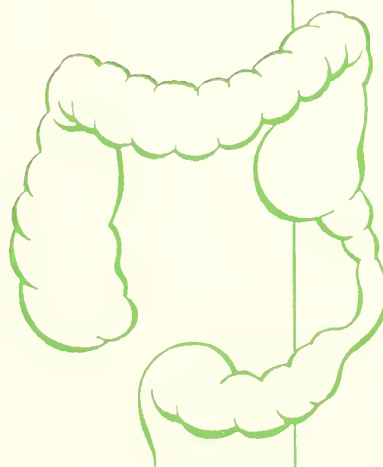
(b) The Board would call to the attention of the General Assembly the section in this law as follows:

"Non-residents. Any person of good moral character licensed by a naturopathic board of any other State whose requirements are commensurate with the requirements of said board upon the payment of Fifty (\$50.00) Dollars shall be granted a license to practice in this State without any further examination."

It is called to the attention of the General Assembly that this provision makes it mandatory upon the Board to grant licenses to practice in this State, if the person has a good moral character, and is licensed by a

Bowel Management of the Irritable Colon . . .

"As an aid in reestablishing a normal rhythm, the temporary use of a bland bulk-producer . . . may be beneficial. . . Patients having irritable colon who believe they are suffering from constipation commonly use high-residue diets, . . . They may not realize that this practice is similar to using irritating cathartics or large enemas and often increases the tendency to constipation by increasing spasm of the colon."*



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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

*Collins, E. N.: The Diagnosis and Treatment of Irritable Colon: Physiologic, Local, Irritative and Psychosomatic Factors, M. Clin. North America 32:398 (March) 1948.

Naturopathic Board of any other State whose requirements are commensurate with ours.

We, therefore, recommend that the word "shall" be stricken out and the words "may in the discretion of the Board" be substituted therefor.

(c) The power of the Board to revoke a license of a practitioner is very restricted, and this Board recommends that this section be amended and enlarged. A proposed amendment is attached hereto and marked Exhibit E.

(d) It is recommended that, instead of the now required one year pre-medical course, this be increased to two years pre-medical course for all subsequent applicants; so that the requirements shall be a graduate of a four-year High School course, a two-year pre-medical course, and at least four years of nine months each of a total number of 4400 hours in an accredited recognized school of Naturopathy before an applicant can take the examination before this Board.

Respectfully submitted,

M. S. DANTZLER, N. D.,

President;

W. T. BIDWELL, N. D.,

LeROY RYAN, N. D.,

J. B. BRANYON, N. D.,

Secretary

By-Laws

South Carolina Surgical and Obstetrical Care Plan

Article I

Principal Office and Seal

Section 1. The principal business office of the Corporation shall be in _____, county of _____, State of South Carolina.

Section 2. The seal shall be circular in form with the words "South Carolina Surgical Service" around the periphery and the words and figures "1948-Blue Shield" within.

Article II

Membership of Corporation

Section 1. The members of the Corporation shall consist of those persons who shall from time to time compose the House of Delegates of the South Carolina Medical Association.

Section 2. Each member of the Corporation shall be entitled to one vote.

Section 3. The annual meeting of the members of the Corporation for the election by ballot of Directors and the transaction of such other business as shall properly come before the meeting shall be held at the time and place of the annual meeting of the South Carolina Medical Association, or at such other time and place as may be stated in the call of the meeting. In case the annual meeting of the members of the Corporation shall not be duly called and held, the Board of Directors shall call a special meeting of the members of the Corporation in lieu of and for the

purpose of such annual meeting and all proceedings at such special meeting shall have the same force and effect as at an annual meeting of the Corporation.

Section 4. Special meetings of the members of the Corporation shall be called by the Secretary (See Article V—Officers) of the Corporation, whenever the Board of Directors or the President of the Corporation shall so order, or upon written request of 15 or more members of the Corporation. The call for such special meetings shall state the purpose of the meeting.

Section 5. Notice of the annual meeting and of all special meetings of the members of the Corporation shall be given by the Secretary of the Corporation by mailing and delivering to each member, at least seven days before the day fixed for the meeting, a notice stating the place, day, hour and purpose of the meeting.

Section 6. At every meeting of the Corporation there shall be present in person at least 25 of the members to constitute a quorum, but a smaller number may adjourn from time to time.

Section 7. Members may waive notice of a meeting by a writing signed before or after such meeting, and if present at any meeting shall be conclusively presumed to have received due notice thereof.

Article III

Board of Directors

Section 1. The affairs, property and business of the corporation shall be managed by a board of fifteen directors, who may exercise all such powers of the Corporation as are not by law or by these By-laws required to be otherwise exercised. Directors need not be members of the Corporation (House of Delegates), but may so be.

Directors shall be nominated by the Council of the Association and shall be elected by the House of Delegates of the South Carolina Medical Association, sitting as the Corporation. At least eight of the Directors shall be doctors of medicine, licensed to practice medicine in the State of South Carolina under the Medical Practice Act (Art. 7 of Chapter 121, Sections 5149-5167 of Code of Laws of South Carolina) and engaged in the active practice of medicine in the State. At least one member of the Board shall be a member of the Board of Directors of the South Carolina Hospital Service Plan, and at least one member shall be elected from Agriculture, one from Labor, one from Industry, and one from Commerce or Business.

Section 2. The members of the proposed Corporation (House of Delegates) at their first meeting shall elect five Directors to hold office until the first annual meeting of the Corporation, five to hold office until the second annual meeting, and five to hold office until the third annual meeting. At each annual meeting the members of the Corporation shall elect five Directors to hold office for a term of three years and thereafter until their successors are elected.

Section 3. Any Director may be removed from office for cause by a majority of the members of the Corporation (House of Delegates) either by writing

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From where I sit *by* Joe Marsh

To Dunk or Not To Dunk?

Dunking doughnuts is Sober Hopkins' favorite morning pastime . . . and for a long time now Ma Hopkins has been trying hard to break him of the habit. She feels it sets a bad example for the children.

So one morning she puts a real heavy frosting of chocolate on the doughnuts . . . figuring that will surely stop him. Sober thinks it over for a little while and then: Dunk! Taste? Smile!! And Sober compliments the missus on the lovely mocha flavor!

I guess there'll always be two schools of thought: to dunk or not to dunk. But from where I sit, it's a matter of personal choice and taste—like some folks prefer beer to cider, ale to beer. And the less we criticize those differences of taste, the better.

In fact, Ma Hopkins got so curious about the flavor of chocolate-covered doughnuts dunked in coffee, that she tried it herself. Now—you've guessed it—she's a daily dunker, too!

Joe Marsh

filed with the Secretary of the Corporation or by a vote passed at a meeting of the members of the Corporation.

Section 4. Vacancies in the Board of Directors occurring during the year shall be filled by a majority vote of the Council of the South Carolina Medical Association present at the meeting of the Council duly called for such purpose.

Section 5. A majority of the Directors in office for the time being shall constitute a quorum for the transaction of business, but a smaller number may adjourn from time to time.

Section 6. Regular meetings of the Directors shall be held immediately after adjournment of the annual meeting of the members of the Corporation at the place of holding the annual meeting and at such regular times and places as the Board of Directors may determine. Special meetings may be held in like manner and shall be called by the Secretary of the Corporation whenever the President or any three Directors shall so request in writing, and seven days' notice of such meetings shall be given to each Director not joining in the request for such meetings. Directors may waive notice of such a meeting by a writing signed before or after such meeting and if present at any meeting shall conclusively be presumed to have received due notice thereof.

Section 7. The Board of Directors shall have power to purchase any property or rights and to enter into any contracts which they deem advantageous to the Corporation, to fix the price to be paid by the Corporation for such property, rights, contracts, to borrow money, to issue bonds, debentures or other securities of the Corporation and pledge or sell the same for such sums and at such prices as they may deem expedient; to adopt rules and regulations subject to the provisions of Article IV hereof and in general to exercise such other powers and to do all such other things as are not required by any other article of the By-laws to be exercised or done by any committee named therein. The afore-mentioned powers shall be exercised by the Board of Directors subject to the provisions of the act (the enabling act), the charter, and the rulings of the South Carolina Insurance Commissioner.

Section 8. Directors as such, shall not receive any stated salary for their services, but by resolution of the Board, a reasonable fixed sum and expense of attendance, if any, may be allowed for attendance at Board meetings. Nothing herein shall be construed to preclude a Director from serving the Corporation in any other capacity and receiving remuneration for such service.

Section 9. The Board of Directors may from time to time delegate any of its powers to committees or officers, attorneys or agents of the Corporation subject to such regulations as may be adopted by the Board, provided, however, that no such delegation of its powers by the Board of Directors shall relieve the

Directors of the duties and obligations imposed upon them by the statutes of the State of South Carolina or by the By-laws.

Article IV Committees

Section 1. There may be appointed such committees as the Directors deem necessary, and there shall be appointed a Central Professional Service Committee as provided herein.

Section 2. There shall be a Central Professional Service Committee composed of five Directors appointed by the President of the Corporation, of whom four, including the Chairman, shall be physicians. The Chairman shall be designated by the President of the Corporation.

Section 3. The Central Professional Service Committee shall have delegated to it supervision over medical aspects of all matters relating to (a) the standards of medical care to be furnished subscribers, (b) qualifications of specialists, (c) the extent and classification of medical benefits to be furnished subscribers, (d) the determination of income groups eligible to become subscribers, (e) the compensation fee schedule to be paid participating physicians, and (f) the admission, suspension and discipline of participating physicians. All rules and regulations of the Corporation relating to the foregoing shall be initiated by this committee provided, however, that any rule or regulation relating to the determination of income groups eligible to become subscribers shall first be approved by the House of Delegates of the South Carolina Medical Association. Whenever the committee shall initiate any change in a rule or regulation it shall be submitted first to the Board of Directors for approval, and then to the members of the Corporation (House of Delegates).

Section 4. In the event of a complaint relative to the conduct or services of a participating physician or of any controversy between a participating physician and a subscriber or whenever it has reason to believe that a participating physician has been guilty of a violation of the rules and regulations of the Corporation, or unprofessional or unethical conduct or of conduct which is liable to endanger the interests of the Corporation or of any of its subscribers, the Central Professional Committee shall investigate the matter and if it shall appear that there is reasonable cause to believe that the participating physician has been guilty of a violation of the rules and regulations of the Corporation, of unprofessional or unethical conduct which is liable to endanger the interest of the Corporation or any of its subscribers, it shall assign a date for a hearing, giving the participating physician concerned at least seven days' notice thereof. If after the hearing at which the participating physician shall be given opportunity to be heard, the said committee shall find the said physician guilty, it shall recommend to the Board of Directors that the agreement between the said physician and the Corporation be terminated or it may recommend any other disciplinary action which

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BIBLIOGRAPHY: 1. Simon S.: J.A.M.A. 138:127, 1948.
2. Pearman, R. O.: New England J. Med. 228:507, 1943. 3. Kearns, W. M., Hefke, H., and Morton, S. A.: J. Urol. 56:392, 1946

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is proper and appropriate.

Section 5. The Central Professional Service Committee shall report its acts and proceedings to the Board of Directors at such times as the Board shall require.

Article V

Officers

Section 1. The officers of the Corporation shall be a President, a Treasurer, a Secretary, a Vice-President and such subordinate officers as the Board of Directors shall from time to time elect with such duties and powers and for such terms of office as the Directors may designate. The President and Vice-President shall be chosen from among the Directors of the Corporation, but other officers need not be. The Directors at their annual meeting in each year shall elect the aforesaid officers, provided, however, that the incorporators (Council) at their first meeting shall elect a Treasurer and a Secretary to hold office until the first annual meeting. All of the said officers shall hold their respective offices for one year and thereafter until their successors are elected and qualified, unless a different term shall be designated by the Directors, subject, however, to removal at any time by vote of a majority of the Board, except that officers elected at the first meeting of the Board shall hold office until the first annual meeting thereafter. Vacancies in any of the said offices shall be filled for the unexpired portion of the term by the Board of Directors. Officers may be paid such salary or compensation as the Board shall determine.

Section 2. The President shall be the chief executive officer of the Corporation. He shall preside at all meetings of the Board. He shall see that all orders and resolutions of the Board are complied with.

Section 3. The Treasurer shall have charge of the Corporation's financial affairs, subject, however, to the supervision and control of the Board of Directors. He shall have custody of all money and securities except his own bond, which shall be kept by the President. He shall deposit all money and valuables in the name and to the credit of the Corporation in such banks as shall be determined by the Board of Directors. He shall disburse the funds of the Corporation as ordered by the Board. He shall keep or cause to be kept, the Corporation's accounts in suitable books, wherein every transaction shall be accurately recorded, and shall render to the Board at regular meetings, or whenever they require it, an account of his transactions and of the financial condition of the Corporation. He shall give bond for the faithful discharge of his duties in such form and in such amount as the Board may require.

Section 4. The Secretary shall keep records of all meetings of the Corporation, and shall give notice of all meetings required by these By-laws.

Article VI

Subscribers

Section 1. Persons insured by the Corporation shall be termed subscribers and they shall be divided into two classes, namely, unlimited subscribers and limited subscribers.

Section 2. Unlimited subscribers are restricted to persons residing within the State of South Carolina, whose annual income does not exceed such amount as shall be fixed by the Board of Directors, as provided in Article IV, Section 3, and who make application to become subscribers as one of such a group as the Board of Directors may specify.

Section 3. Limited subscribers are restricted to persons residing within the State of South Carolina, whose annual income exceeds such amount as shall be fixed by the Board of Directors, and who comply with such terms and conditions as the Board of Directors may by regulation present.

Section 4. A subscriber shall be entitled to receive from a participating physician such medical services as are included in the subscriber's contract with the Corporation, subject to whatever rules and regulations may be adopted by the Board of Directors relative thereto. The Corporation shall have no supervision over the amount to be charged by a participating physician to a limited subscriber.

Section 5. Subscribers shall have free choice among participating physicians, subject to the provisions of Article VII, Section 3, hereof, and to rules and regulations adopted by the Board of Directors.

Section 6. The Board of Directors shall have power to enter into arrangements and agreements with employers, societies, charitable or other organizations, and governmental agencies and authorities for the payment of part or all of the cost of medical care furnished to any person who may be entitled to such care under the rules and regulations adopted by the Board of Directors.

Article VII

Participating Physicians

Section 1. Any physician licensed under the Medical Practice Act (Article 7 of Chapter 121, Section 5149-5167 Code of Laws of South Carolina) to practice in South Carolina may become a participating physician on complying with the provisions of these By-laws and the rules and regulations of the Corporation.

Section 2. A physician desiring to become a participating physician shall make written application in the form prescribed by the rules and regulations and shall before becoming entitled to act as a participating physician, enter into a written agreement with the Corporation in the form prescribed by the rules and regulations.

Section 3. Subject to the code of ethics of the American Medical Association, a participating physician shall have the right to accept or reject patients so far as subscribers are concerned and the right to dis-

continue treatment of any subscriber according to the code of ethics of the American Medical Association, provided, however, he shall not have the right to refuse to accept a subscriber as a patient or to continue treatment of a subscriber *for the reason that he is a subscriber* and such refusal shall constitute grounds for termination by the Corporation of its agreement with a participating physician.

Section 4. A participating physician shall not request or accept from anyone whom he knows to be an unlimited subscriber any compensation for such services as such subscriber is entitled to under his contract with the Corporation, except such charges, if any, as may be provided in the rules and regulations adopted by the Board of Directors and set forth in the subscription certificate.

Article VIII

Amendment of By-Laws

Section 1. These By-laws may be amended or repealed by vote of a quorum of the members of the

Corporation (House of Delegates of the South Carolina Medical Association), or at a special meeting called for the purpose, of which due notice has been given to each member with a copy of the proposed amendments. Copies of all amendments to the By-laws shall be filed with the Commissioner of Insurance within thirty days after adoption.

The committee believes that in adopting the recommendations hereby presented, the Council will have taken the next necessary effective step in setting in operation a Blue Shield Plan for South Carolina.

The next steps will be to get approval of the plan by the House of Delegates, the selection of a Board of Directors, and the selection of a committee to study and prepare a fee schedule. From there on the Board of Directors will have to take over.

J. Decherd Guess, M. D.

Chairman, Committee on

Medical Service

Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT NO. 624

Student B. L. Barnett, presenting:

HISTORY: A 69 year old negress admitted to hospital 12/19 in an unconscious state and the following history obtained from a cousin. Patient has lived alone for a number of years and worked regularly in a laundry for 35 years. She went to work as usual on 12/16. The following morning neighbors summoned her cousin because they noticed lack of activity about the house. The door was broken in and the patient found lying unconscious on the floor. It was noted that she had no movement on her right side. She was kept at home until the morning of the 19th because of fear of "getting in trouble with the coroner." Patient has remained unconscious with paralysis of right side. No nourishment since onset of present illness and only enough water with a spoon to "keep her throat wet."

PAST HISTORY: Has had some headache and vertigo for 3-4 years. She was in hospital 1 year previously with prolapse of uterus. At that time B. P. 160/115; also stated that she had had exertional dyspnea for 2 weeks as well as substernal pain associated with exercise. Heart enlarged with extrasystoles. She was not considered a good operative risk and discharged to clinic.

PHYSICAL EXAMINATION: T-97.6, P-120, R-24, B.P. 120/90. Aphasic, uncooperative with right hemiplegia. Pupils round, regular, and equal. React to light.

Fundi: Some sclerosis of retinal vessels. Neck veins moderately distended. Slightly diminished breath sounds with rales over right lower lobe. Respirations said to be of Cheyne-Stokes type. All peripheral arteries pipe-stem in character. **Heart:** PMI in 6th ICS in anterior axillary line. Definite pulse deficit with beats irregular in volume and rhythm. Extrasystoles every 4th-5th beat. Abdomen essentially negative. Muscles of the right extremities are flaccid and without movement. Eyes fixed straight ahead and there is no demonstrable facial weakness.

LABORATORY DATA:

Urine:	Sp. Gr.	Alb.	WBC	Casts
12/19	1.014	++	12 HPF	0
1/7	1.016	+++	20 HPF	+ fine gran.
Blood:	RBC	WBC	Hb.	PMN
12/19	4.64	21,900	13 Gm.	89%
12/20		17,800	11 Gm.	
12/27		28,500	8.5 Gm.	83%
1/7	3.28	37,700	10 Gm.	91%

Spinal Fluid: Opening pressure 100. Frecc dynamics. Clear. 93 cells. 40% PMN, 60% lymphs. Total protein 71 mg. Wass. and Kline neg.

Urea N. 78 mg.) 66 mg.)
) On admission) Day before
 Creatinin 2.32 mg.) 2 mg.) death.

X-ray of chest, EKG available.

COURSE: Heart action continued to be very

irregular. Developed frank dry gangrene of left foot and leg on 12/29. Tourniquet and refrigeration employed. Condition remained critical and patient died after 20 days in hospital.

Doctor Ralph Coleman, Conducting:

Dr. Coleman: Mr. Thomas, will you begin the discussion on the case?

Student Thomas: This is a case of a 69 year old negro who according to the history was able to get along fairly well until she was found unconscious and was admitted in shock with right hemiplegia. There is a history of exertional dyspnea and the finding of retinal sclerosis. These would indicate a rather considerable degree of arteriosclerosis and the picture could be explained on the basis of a cerebral vascular accident. One would have to consider hemorrhage into the internal capsule as a possible cause for this. There is no facial weakness mentioned and an internal capsular lesion would best explain this. The respirations were of Cheyne-Stokes type and there were diminished breath sounds and rales in the right lower lobe. The blood urea nitrogen is moderately elevated. These findings would indicate some degree of cardiac decompensation. The leucocyte count of 21,900 is probably due to an early bronchopneumonia. The statement that "trouble with the coroner" was feared could lead one to suspect a blow on the head. There is certainly no indication of this and the spinal fluid pressure is not increased. I believe the main thing to consider, though, is generalized arteriosclerosis with a cerebro-vascular accident involving the internal capsule.

Dr. Coleman: Be more specific.

Student Thomas: Well, the patient apparently had auricular fibrillation and she may have had a cerebral embolus. The dry gangrene of the foot could be explained on an embolic basis.

Dr. Coleman: Then your diagnosis is auricular fibrillation with multiple embolisation, including the brain.

Student Thomas: Yes.

Dr. Coleman: Why the diagnosis of fibrillation?

Student Thomas: Well, there is a pulse deficit.

Dr. Coleman: Will any other arrhythmias produce a pulse deficit?

Student Thomas: I don't know, but this is certainly the most common one.

Dr. Coleman: Would you need anything else to establish diagnosis?

Student Thomas: An EKG would be helpful. (Views EKG). The EKG could fit auricular fibrillation. I do not see any T waves except in lead I, and there they are not conclusive.

Dr. Coleman: What about the pulmonary lesion?

Student Thomas: Well, the patient either had cardiac decompensation or pneumonia. The rising white cell count certainly fits infection somewhere.

Dr. Coleman: Why bronchopneumonia?

Student Thomas: Well, the patient was found after a day or so of unconsciousness. The pneumonia could be on an aspiration basis. May I see the X-rays. (Views X-rays) These films fit the picture for broncho-

pneumonia.

Dr. Coleman: What about the renal function?

Student Thomas: The specific gravity is rather low for the limited intake that she had, but after hydration the specific gravity was 1.016. She probably had some renal arteriosclerosis associated with the high blood pressure.

Dr. Coleman: Do you think that she had advanced kidney damage?

Student Thomas: She had some kidney damage, but not serious. It's hard to evaluate the urinary findings in a voided specimen. The pus and albumin may be related to some vaginal discharge.

Dr. Coleman: What about the blood urea nitrogen?

Student Thomas: Well, she had some chronic kidney disease, probably on a vascular basis and this with the cardiac decompensation could easily produce this elevation of urea nitrogen. There is no acute or severe process present, however.

Dr. Coleman: Mr. Richardson, do you agree?

Student Richardson: I think that this patient had a cerebro-vascular accident. The exact type would be hard to say. There is certainly no strong evidence of embolism so that one might expect a thrombosis or hemorrhage. Insofar as the heart is concerned it is most likely auricular fibrillation. The kidney shows no evidence of embolic phenomenon. The dry gangrene of the leg is probably on the basis of arteriosclerosis and thrombosis. The brain lesion is probably on the basis of a thrombosis because the onset is apt to be more gradual and statistically thrombosis is more common than hemorrhage. The vertigo and headaches would indicate a long standing elevated blood pressure. The density in the right lower lobe suggests bronchopneumonia. However, the possibility of an embolus with infarction and infection must be considered for the white blood count is higher than with bronchopneumonia.

Dr. Coleman: I would like to say that there are other arrhythmias which may produce pulse deficits. Another common one is premature contractions. Statistically thrombosis is much more likely than a cerebral embolus. The pulmonary lesion is most likely related to the vascular disease, as the white count is more elevated than usually seen in bronchopneumonia. The electrocardiogram in this case shows premature contractions.

Dr. Kredel: I would like to comment on the 93 cells in the spinal fluid. It indicates a large area of brain involvement which extends to reach the cortical or ventricular surfaces.

Dr. H. R. Pratt-Thomas: Final Pathological Diagnosis: Embolism of Lung with Infarction and Abscess. Abscesses and Encephalomalacia of Brain. Gangrene of Left Foot.

It appears that the infarct of the lung was the initial episode as regards this patient's final illness. Following an embolus to the lung, infarction and infection occurred and then a shower of emboli from the pulmonary focus reached the brain. The source for the original embolus is debatable. It could easily have



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Fellow of the American Psychiatric
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come from the leg or pelvic veins, but its definite source was not discovered at necropsy. The embolism and infarction of the right lower lobe are of some age as shown by the degree of organization of the clot within the vessels. The brain showed focal areas of softening and abscess formation in the left cerebral

hemisphere which involved cortical, subcortical and internal capsular areas. There was also marked cerebral and coronary arteriosclerosis with some fibrosis of the myocardium. There was a moderate degree of acute and chronic pyelonephritis and an acute cystitis.

BOOK REVIEWS

NURSING FOR THE FUTURE

Nursing is everybody's business. The theme of the recent South Carolina Nurses' Association was "America's Nursing Care a Professional challenge and a Public Responsibility." In Dr. Lucille Brown's report, made in cooperation with the National Nursing Council and called NURSING FOR THE FUTURE, the emphasis is on good nursing care rather than on the nurse. This report was published by the Russell Sage Foundation, and so important was it considered that copies have been sent free to key people in each state. This report takes up:

HOSPITAL AND HEALTH SERVICES OF THE FUTURE

The hospital as a community health centre is seen, and it is to be related to other community agencies in ways heretofore unknown. Better quarters are to be provided, instead of basements and semi-basements for some of the services. Laboratories are to be available to private physicians as well as to the hospital staff. Diagnostic clinics and offices for the staff should be established in hospitals. The extension of group medical practice is to be encouraged.

The plan for the future is for a few big hospitals, as centres with adequate personnel, equipment, and a School of Nursing, Medical School and University affiliation, to be a medical teaching centre for post-graduate study. Around these should be grouped smaller community hospitals. These smaller hospitals would in turn have grouped around them local health centres, designed to promote and render rural service. The central hospitals would have a program to promote and improve the quality of hospital and medical care in the whole state. These centres would send men to the community centres to conduct clinics and seminars for physicians practicing in the locality. The central organization would make provision for skilled consultants to respond to calls for assistance from local hospitals.

The community hospital would be a hospital of about 50 beds. Public Health and Medical Service centres would be planned for places too small for that size, but in isolated areas. These would give emergency treatments and have an ambulance service available. These would be under the supervision of the medical staff of the hospital with which the health centre is affiliated.

Recommendations were to bring more nearly into alignment the philosophy and practice of the general hospital and the public health program.

There should be a close relationship so that the educational activities of hospitals include training in public health. There should be integrated action programs involving laboratory tests, x-rays, case finding, maternal and child health clinics, out patient service

and communicable disease control conducted jointly by hospital and health centre. Cooperative programs of health education, preventive medicine, visiting nurse service, and social service and statistical reporting between hospitals and public health departments should be extended.

Extension of health services should be made in the area of prevention and therapy, especially in the destructive "diseases of middle life"—cardiac, cancer and the degenerative process of age. Larger financing of health services are needed through voluntary health insurance. Maintenance of health, rather than just the care of the acutely ill, should be the future goal. The teaching of mental health and preventive medicine should stress maintenance of health. Sickness should be considered a deviation from the normal. Some of the more advanced medical schools have started nursing schools for normal children, for study.

In obstetrics, the preventive or prenatal care is important and the new philosophy of the emotional factors should receive consideration for the elimination of fear and its consequences, by education and relaxation. This is most important. See "Childbirth Without Fear" by Dr. Dick Grantly Reed.

FUTURE DEMAND FOR NURSING

The development of such plans would demand an enormous supply of nursing care that will be needed, if specialized hospitals, as well as general hospitals and public health, industries, municipalities, and other corporate bodies decide to broaden their scope. Nursing and organization have been hindered by the scarcity of nurses with a sufficiently broad education and professional background to staff, plan, administer, teach, and supervise large and intricate nursing services. It is a question as to whether quantitatively and qualitatively a requisite amount of nurses and nursing care can be obtained. In a report from The Woman's Bureau of the U. S. Department of Labor two estimates of 500,000 or 550,000 were given as the number of nurses needed to serve a probable population of 153,000,000 by 1960. The lower of these is not far from 200,000 higher than the number of available nurses in 1946 and represent requirements only, if current standards of nursing are maintained. Twice as many would be needed for expansion. Graduates from 1951 to 1960 would need to average 45,000. The number to be graduated in 1950 will probably be 27,000. Many of these will be lost to the profession.

NURSING EDUCATION

In Dr. Brown's Report, she states: "There is clearly a need for non-graduate nursing service, such as is rendered by the practical nurse, orderly, or attendant." She notes with approval in the 1947 Study of the U. S. Office of Education—that no system of training practical nurses is likely to succeed, unless the public creates broad general policies and provides funds and

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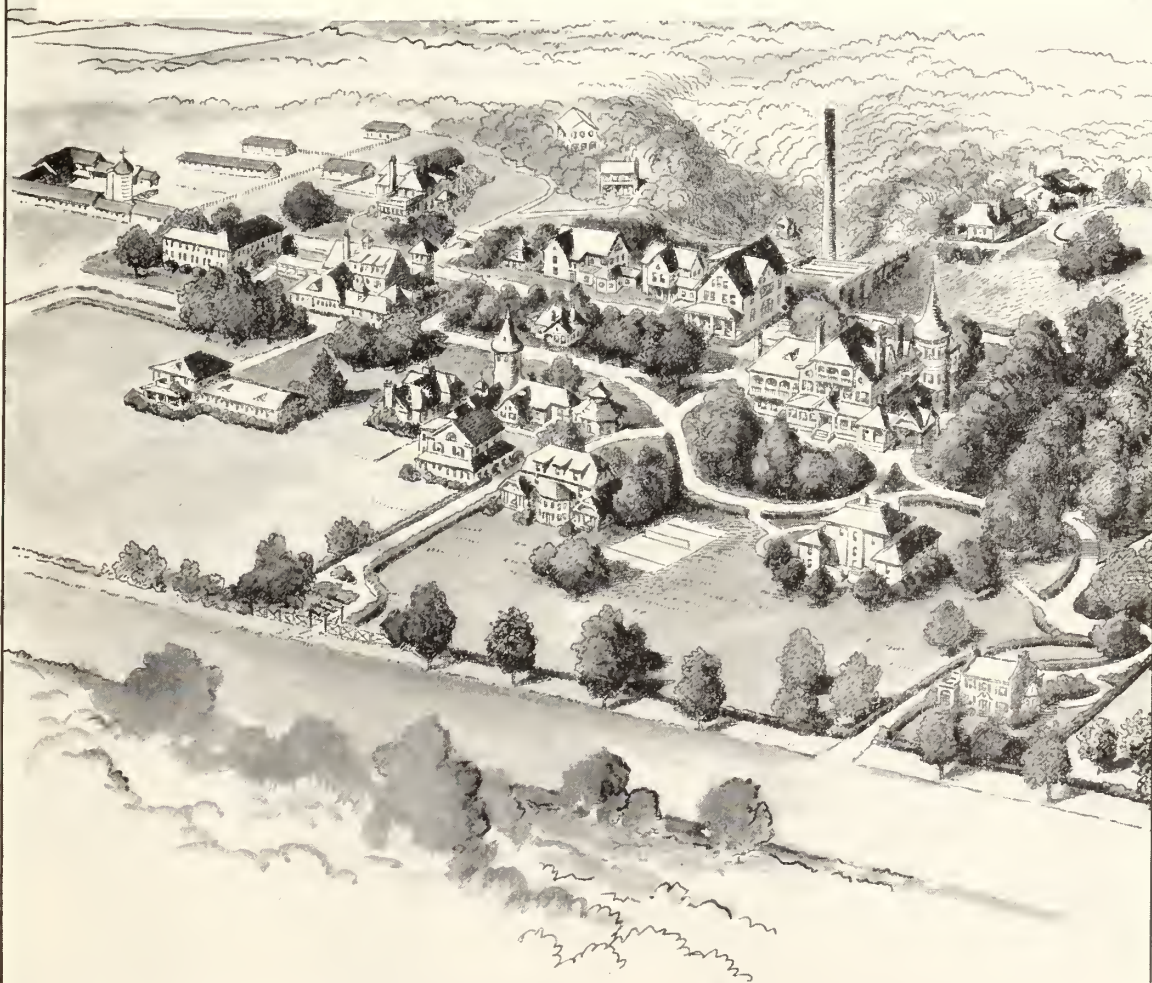
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THOS. F. COATES, JR., M.D.



L I T E R A T U R E O N R E Q U E S T

educators, who design and operate instructional programs, hospitals and agencies that provide clinical facilities and Nursing Associations and State Boards of Control, that set up standards and manifest an active interest in practical nursing, far beyond any interest yet shown.

At the other end of the scale Dr. Brown discusses the functional role of the Professional Nurse, and analyzes some of her responsibilities as a skilled technician, as a minister of the healing art, with emphasis on psychotherapy, and as a specialist in supervision, administration, teaching, consultation, planning and promotion of professional activities and public health nursing. It would be desirable that Chapters 4 and 6 of Dr. Brown's report of *NURSING FOR THE FUTURE* be made required reading for those who are advocating various nostrums for nursing education. Quoted from the *Journal of Public Health*, November, 1948, Dr. Brown recommends that "professional," when applied to nursing education, be restricted to schools, whether affiliated with institutions of higher learning or operated independently, that are able to furnish professional education as that term has come

to be understood by educators. It is urged that individual persons, informed groups and private corporate bodies, including foundations and institutions of higher learning themselves, make the largest sums available for the creation and strengthening of soundly conceived college and University schools of nursing, and that official bodies—local, state and federal—concern themselves at once with nursing education on the professional, as well as the non-professional level. Between these two extremes, the non-graduate and the truly professional nurse, stand the graduates of most of the hospital schools of this country. Whether a middle group of nurses will be desirable, Dr. Brown holds that we cannot conclude today. Many of the schools today should be converted into training centres for non-graduate personnel. The best of the hospital schools should be encouraged to attain professional status by affiliation with adjacent institutions. Nursing should make its important business, the long overdue official examination of every School of Nursing. Today the shortage of nursing personnel makes the solution of nursing problems more urgent than ever before. It is a time for action.

Laura Blackburn, R. N.

NEWS ITEMS

In cooperation with the Department of Medicine of the Graduate School of the University of Florida and the Clinical Society of the Duval County Diabetes Association the U. S. Public Health Service is presenting a seminar on diabetes at the George Washington Hotel, Jacksonville, Florida, March 28 and 29, 1949. The speakers will be as follows:

Dr. Charles H. Best, co-discoverer of insulin; director of Banting and Best Department of Medical Research, University of Toronto; president of American Diabetes Association.

Dr. Elliott P. Joslin, Medical Director of Baker Clinic, Boston, Mass.; author of classic textbook on diabetes treatment.

Dr. Joseph H. Barach, professor of medicine in University of Pittsburgh; director of Falk Clinic; chairman of Metabolism and Endocrinology Study Section of the Research Grants Division of the National Institutes of Health.

Dr. John A. Reed, assistant clinical professor of medicine in George Washington University; attending physician and director of the Outpatient Department of George Washington University Hospital.

Detailed programs will be sent to secretaries of medical societies in the Southeastern States area at a later date. There will be no registration fee. Hotel reservations should be made through Dr. Malcolm J. Ford, Diabetes Demonstration Unit, Box 210, Jacksonville, Florida.

One hundred and thirty-five physicians attended the annual meeting of the Marlboro County Medical Society, held in Bennettsville on January 13. The principal speaker of the evening was Dr. Melvin H. Knisely, Head of the Department of Anatomy at the Medical College in Charleston, who discussed "Sludged blood and some of its implications." His talk was illustrated with moving pictures which he had made himself, and it was enthusiastically received.

Dr. Samuel Kilgore, psychiatrist at Duke University Hospital, was the principal speaker at a joint meeting of the Spartanburg Mental Hygiene Society and the Spartanburg Mental Hygiene Clinic in Spartanburg on January 25.

Dr. J. D. Thomas has been elected President of the Horry County Medical Society for the coming year. Serving with him will be Drs. Cary Durant, J. D. Gilland, and W. K. Rogers, vice-presidents, and Dr. R. C. Smith of Conway, secretary-treasurer.

Mrs. LeGrand Guerry, wife of the late esteemed and beloved surgeon, Dr. LeGrand Guerry of Columbia, died at her home on December 31.

Dr. Chen Chow of China who is on a special mission to the United States to study American hospitals was a visitor at the Cherokee County Hospital during the early part of January.

Dr. Delmar O. Rhame of Clinton was elected president of the Third District Medical Society for the coming year. Dr. A. E. Poliakoff of Abbeville was elected vice-president, and Dr. John W. Bell of Greenwood, secretary-treasurer.

Dr. Grady Callison has resigned his position as director of the Division of Local Health Services of the State Board of Health and is now serving as director of the Anderson County Board of Health.

The following physicians have been elected officers of the Columbia Medical Society for the coming year: Dr. Charles H. Epting, President, Dr. Manly Hutchinson, Vice-President, Dr. Gordon Seastrunk, Secretary, Dr. Walter Masters, Treasurer, Dr. Joe Freed, Editor of the Recorder.

The Chester County Medical Society held its first meeting of the year in the dining room of the Pryor Hospital on January 4, 1949. A splendid dinner was served by Mrs. Hardin, the dietician.

The new officers were inducted into office who are



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Dr. C. C. Smith, president, Dr. V. P. Patterson, vice-president, Dr. M. L. Marion, secretary and treasurer, and Dr. J. N. Gaston, Jr., delegate to the South Carolina Medical Association.

Dr. W. J. Henry, the legislative representative in this county, reported on a meeting of the council in Columbia at which time our state officers outlined the plans to oppose the impending legislation in Washington, attempting to socialize medicine. It was decided to devote the next meeting which will be February 1st, to a discussion of this matter and to invite the dentists and druggists to meet with us.

The guest speaker, Dr. Charles Poole of Spartanburg, was introduced by Dr. Wallace and gave a most interesting and informative address on Anesthesia. Several dentists were present to hear this subject discussed.

Arrangements are being made to have three films shown at the March meeting. One will deal with surgery, one with medicine, and one with dentistry. Dr. Patterson, who is an expert amateur photographer and camera-man will have charge of the meeting.

The annual meeting of the Georgia Society of Ophthalmology and Otolaryngology will be held at the General Oglethorpe Hotel in Savannah on March 4-5, 1949.

The distinguished lecturers and their tentative subjects are: Dr. Paul A. Chandler of Boston, Glaucoma Management; Dr. Jack S. Guyton of Baltimore, Cataract Management; Dr. Oscar C. E. Hansen-Pruss of Durham, Allergy of the Upper Respiratory Tract; Dr. Marvin F. Jones of New York, Management of Ear Problems in Children and An Otological Survey; Dr. Ralph O. Rychener of Memphis, External Eye Diseases and Dacryocystitis; Dr. Fletcher D. Woodward of Charlottesville, Problems in Laryngology.

THE AMERICAN ACADEMY OF ALLERGY

Announces

FIVE DAY ORIENTATION COURSE IN ALLERGY

March 7-11 (Inc.), 1949

The American Academy of Allergy, in cooperation with the University of Georgia, will sponsor an orientation course in allergy from March 7 through March 11, 1949, at the University Medical School in Augusta, Georgia. This course is under the direction of Dr. Leo H. Crip, assisted by other Fellows of the American Academy of Allergy, and a distinguished faculty.

The course is intended for internists and general practitioners, dermatologists, rhinologists and nose and throat men. The course content will be exceedingly practical and directly applicable to the practice of most physicians doing general medicine. It will include lectures and clinical demonstrations on allergens, hay fever, bronchial asthma, diagnosis and treatment, diagnosis, etiology, pathology and immunology of allergy, allergic rhinitis, atopic dermatitis and other significant manifestations in the field.

Enrollment is open to anyone interested and the fee is fifty dollars. Applications and inquiries should be addressed to the Executive Office of The Academy, 208 East Wisconsin Avenue, Milwaukee 2, Wisconsin.

CORRESPONDENCE

STATE BOARD OF HEALTH OF SOUTH CAROLINA Columbia 10, S. C.

Dear Sir:

Since early in 1946 we have been distributing to you dried blood plasma which was surplus to the Army needs and returned to the American Red Cross for distribution to the civilian population. At that time it was estimated that this surplus supply would last about two years.

We have been notified as of December 31 that this supply has been exhausted and there will be no further shipments available.

As you know, the American Red Cross is undertaking a program to establish blood banks throughout the country to continue furnishing needed blood and plasma to the American people. This program is headed by Admiral Ross T. McIntyre, U. S. Navy, retired. They have tentatively planned to organize blood banks to furnish the entire country with blood and blood derivatives. A bank has already been established in Atlanta for that area; one is in the process of being established in Charlotte for that area and preliminary steps have been taken to establish one in Columbia, S. C. Each bank is designed to supply about a seventy-mile radius.

Again assuring you of our pleasure in working with you on this program, we are

Very truly yours,

Ben F. Wymann, M. D.
State Health Officer

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The Journal of the South Carolina Medical Association

VOLUME XLV

March, 1949

NUMBER 3

Diabetes and Tuberculosis

By

SYDNEY JACOBS, M. D.

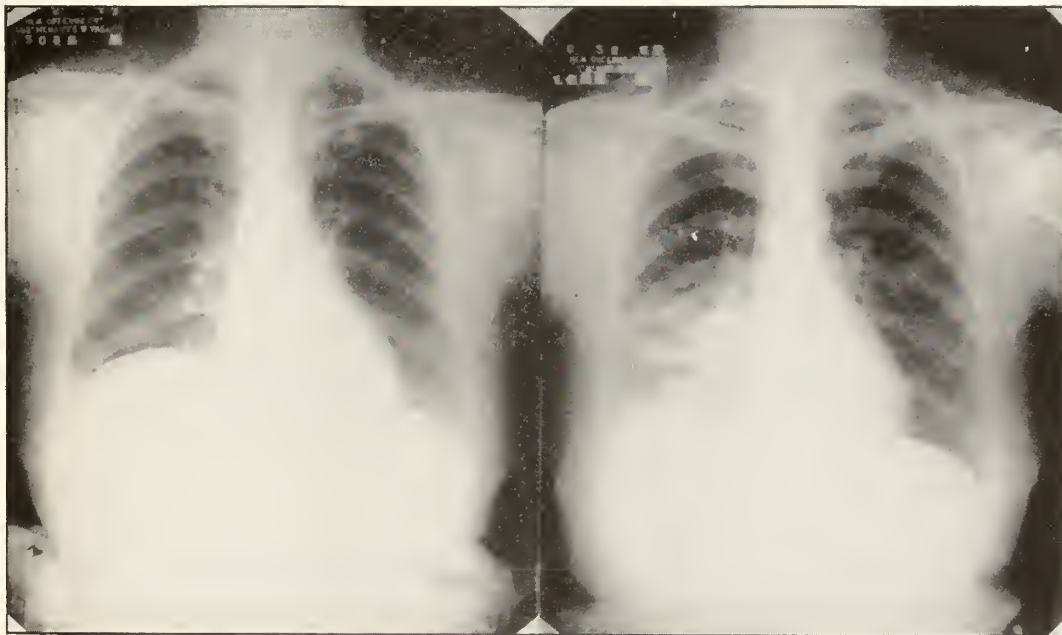
New Orleans

Assistant Professor of Clinical Medicine

Tulane University School of Medicine

Diabetes mellitus and pulmonary tuberculosis frequently coexist. As a rule, the diabetes appears first; the tuberculosis may therefore be regarded as a complication of the diabetes. The pulmonary disease is usually seen as a massive caseous pneumonia developing with almost explosive force in a diabetic past middle age, requiring energetic therapy and

having even more than the usual gloomy prognosis of caseous pneumonia of the non-diabetic. (See Case I). The severity of the diabetes and the severity of the tuberculosis do not seem to be related; the diabetes can be brought under control with relative ease if a suitable diet and enough insulin are used; the pulmonary tuberculosis is amenable to the indicated form



CASE I — FIGURE I

Mrs. A. S., 62 years old, had been treated for diabetes 10 years without event. A routine chest film was entirely normal in 1943. Two years later, she had what was regarded as a right pneumonia, but the area of consolidation rapidly extended until a cavity was formed and tubercle bacilli were found in the sputum.

Presented before the annual meeting of the South Carolina Trudeau Society, Columbia, South Carolina—October 29, 1948.

of collapse therapy but seldom responds to bed rest alone.

There has not been an entirely satisfactory explanation for the marked liability of diabetics to develop tuberculosis. Certainly it cannot depend entirely on the lack of natural resistance of diabetics to the effects of the tubercle bacillus: diabetic children rarely die of pulmonary tuberculosis; when fatality ensues among adults with the combination of the two diseases, it tends to be at the same age as among tuberculosis patients without diabetes; and diabetics have the same incidence of clinically insignificant (presumably healed) pulmonary calcifications as do the nondiabetics.¹

Obviously in the diabetic something happens to depress the resistance to tuberculosis ordinarily provided by the primary tuberculous infection. This "something" defies analysis, but it does seem to make for a soil in which the tubercle bacillus can proliferate more readily than usual. It is not hyperglycemia although this has been often incriminated. Experimental animals rendered hyperglycemic by a combination of pancreatectomy and injections of anterior pituitary lobe extracts are more susceptible to tuberculous infections than nondiabetic controls.² On the other hand, if the hyperglycemia is only partly controlled by inadequate amounts of insulin, wound healing progresses normally. Kecton³ has suspected a localized acidosis as the cause for this susceptibility; the notorious tendency for diabetics to develop tuberculosis within 3 years of recovery from a bout of coma should be remembered. Possibly coma is associated with elaboration of excessive amounts of nitrogenous compounds, excellent culture media for tubercle bacilli. The disordered fat metabolism predisposes to production of large amounts of glycerol, and this may also stimulate proliferation of the mycobacteria. Root has noted large amounts of fat in the reticulo-endothelial system of diabetics and has presumed that this increases the tendency to diabetes.

Banyai⁴ detected avitaminosis among many of his tuberculous patients and regarded this as a probable cause for the increased incidence of tuberculosis among diabetics.

We do not know why diabetics are so prone to develop tuberculosis, but one thing is certain. As Joslin¹ has well put it, "The susceptibility of the diabetic to tuberculosis depends largely on control of the diabetes." Since the advent of insulin and the use of a high carbohydrate diet, it is unusual to see a properly controlled diabetic develop tuberculosis. This is in marked contrast to the period of 1900 when so many patients with diabetes developed tuberculosis that 50% of all diabetic who came to autopsy had evidences of pulmonary tuberculosis.

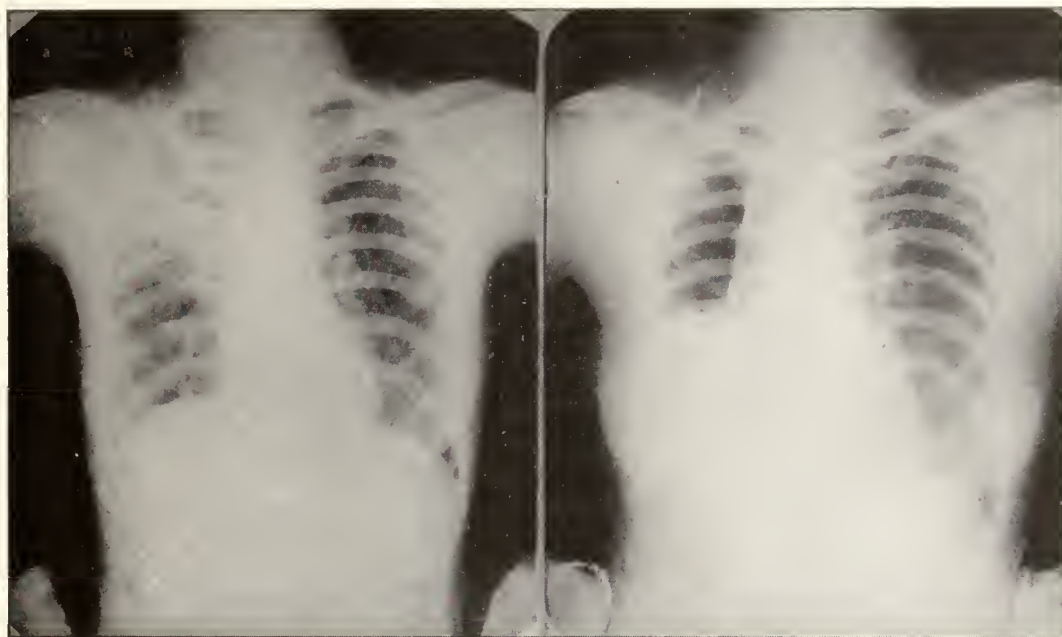
How frequently diabetics develop tuberculosis is still cause for controversy and apparently depends a great deal upon where and how the clinical material

is compiled. McKean, Thostenson and Brooks⁵ found that 1.59% of 15,361 patients who entered the Herman Kiefer Hospital over a period of 10 years had diabetes. Himsworth⁶ reported that 6.5% of 230 consecutive diabetic admissions were complicated by tuberculosis. Root found reinfection tuberculosis to be 13 times as great as expected for Massachusetts school children who developed diabetes before the age of 15 years. Banyai⁷ summarized the literature and found that 2.6% of 8,520 patients with diabetes had tuberculosis or about 3 times the prevailing picture in the population at large. The age incidence parallels that of diabetes rather than of tuberculosis. Whereas tuberculosis in the general population makes its appearance in the second or third decades, in diabetes it appears in the fifth decade thus suggesting that the tuberculosis develops on account of the pre-existing diabetes.

One of the most important studies of all was that of Rubin⁸ who examined 414 tuberculous patients past the age of 50 and found that 17% had diabetes.

Inasmuch as our population is aging, and in doing so is developing more than its former share of diabetics, it is highly probable that we shall face an increased proportion of tuberculous among the aging diabetics of the future. Many of these diabetics will doubtless conform to the "liver dysfunction hyperglycemia" described by Taub, Sholes and Rice.⁹ The increased life span of the diabetic provides, and will continue to provide, greater opportunity for co-existence of these two diseases. It should be recalled that some years ago, Israel Dublin predicted that before long death rates from diabetes would exceed those from tuberculosis. The latest statistics of the Metropolitan Life Insurance Company sustain this prediction. The public health implications of this phenomenon can be appreciated; most of the persons in this older age group will expel tubercle bacilli promiscuously; tuberculosis of the aged is notoriously difficult to control.

The diabetic almost always has a caseous pneumonia at the time of diagnosis of his tuberculosis, and—except where discovered during a case-finding survey—it is in the far advanced stage. The clinical onset is explosive (Case II) as would be expected of a rapidly extending lesion. Usually tuberculosis is first suspected when the previously stable diabetes cannot be suitably maintained. Invariably there are x-ray evidences of massive infiltrations which coalesce into irregular areas of consolidation with central rarefaction. At times, the process extends from the hilus into the midzonal and basal regions. Except for apical fibrotic disease, progression is the rule. At autopsy, these widespread areas of tuberculous pneumonia are found to contain soft-walled yellowish cavities with little productive reaction. In keeping with the caseous phase of the disease when diagnosed, very few pleural adhesions are encountered. Possibly as a result of the rapid spread of the disease, laryngeal and intestinal



CASE II — FIGURE II

L. L., a 55 year old white female had been treated for diabetes for 10 years before the discovery of a tuberculous caseous pneumonia in 1938. Artificial pneumothorax was successfully induced and maintained but the lung could not be re-expanded. Tuberculous empyema developed when attempts at re-expansion were instituted.

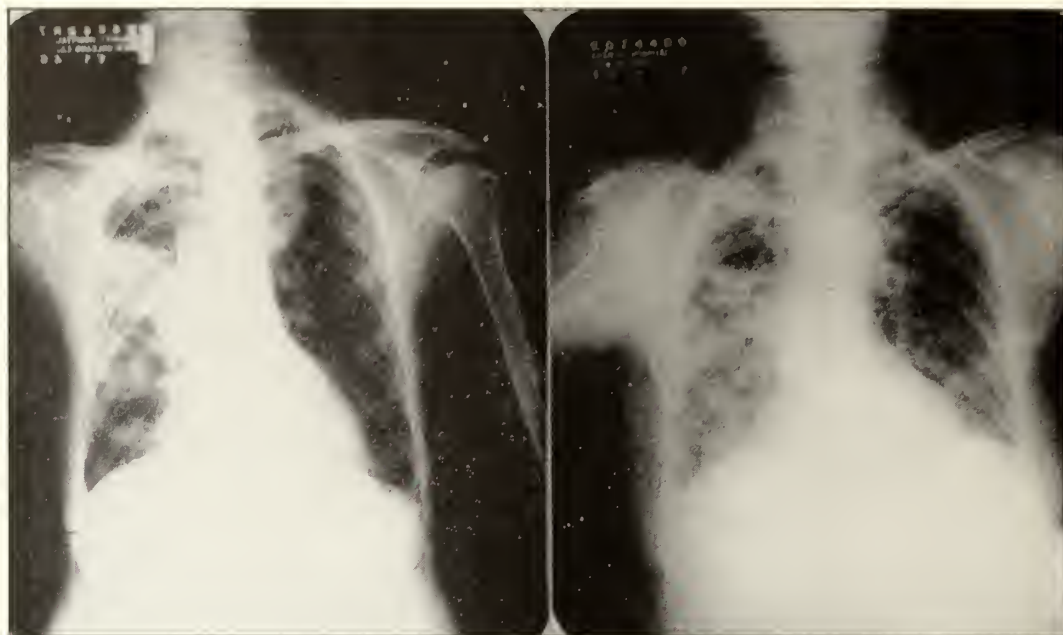
complications are infrequent. Tracheobronchial tuberculosis is a frequent concomitant.

The prognosis is poor as is always true for caseous pneumonia. Diabetes when combined with active pulmonary tuberculosis often reduces the life expectancy to three years or, at best, to about one half that of the patient without diabetes. This type of caseous pneumonia is similar to that frequently seen among nondiabetic whites and among negroes who have lived on a suboptimal diet for a long time. It bespeaks a poor resistance to the ravages of the tubercle bacillus. Rubin found that 90% of his patients were dead of tuberculosis within 6 months of admission to the sanatorium. Our mortality rates are not so high but they do indicate the severity of this type of disease.

The diabetes must be controlled first. We have found that almost always is insulin needed. No attempt is made to control the diabetes without insulin; this would mean feeding the patient a diet too low in caloric content to maintain adequate nutrition. It is a common observation that a diabetic who begins to lose weight when he develops tuberculosis will need smaller amounts of insulin as his weight declines but will require more insulin as gain in weight occurs along with subsidence of his tuberculosis toxemia. Because of fluctuations in the carbohydrate metabolism caused by fever, toxemia and surgical intervention, complicated additionally by caprice of appetite, it is

not feasible to adhere too rigidly to an attempt to obtain a normal fasting blood sugar level and absence of sugar from the urine. For this reason, a slowly absorbed insulin, such as globin or protamine zinc insulin, has been used most advantageously. This avoids the dangers inherent in acidosis or hypoglycemia. It is well not to depend on blood sugar estimations once the initial diagnosis has been established but to rely on fractional urinalyses. The patient who does not eat all at a given meal is sent a replacement of fruit juice for the rejected food. In this manner, it is possible to maintain an adequate balance and to avoid the development of hypoglycemia among those too sick to eat their full rations. The usual diet averages 175 grams carbohydrate, 80 grams protein and 100 grams fat; this is not an arbitrary choice, and the proportions of the respective components is altered in accordance with otherwise recognized indications.

Because the tuberculosis is almost always in the stage of caseous pneumonia when diagnosed, all the liabilities of tuberculous pneumonia are encountered. These patients are quite sick on admission but usually begin to feel much better within 2 weeks after bed rest and dietary management are instituted. Although the symptoms of tuberculosis subside, progression of the disease will deceptively continue unabated. Our ideas have changed considerably in the past decade concerning the therapeutic approach to this problem. At one time we advocated a period of waiting for the caseous pneumonia to undergo some resolution and



CASE III — FIGURE III

G. F., 72 year old white female had been treated for diabetes for at least 5 years before the recognition of pulmonary tuberculosis. Because of her senile psychosis, the history was not reliable. Her age contra-indicated collapse therapy. The slow progression of the disease is evident.

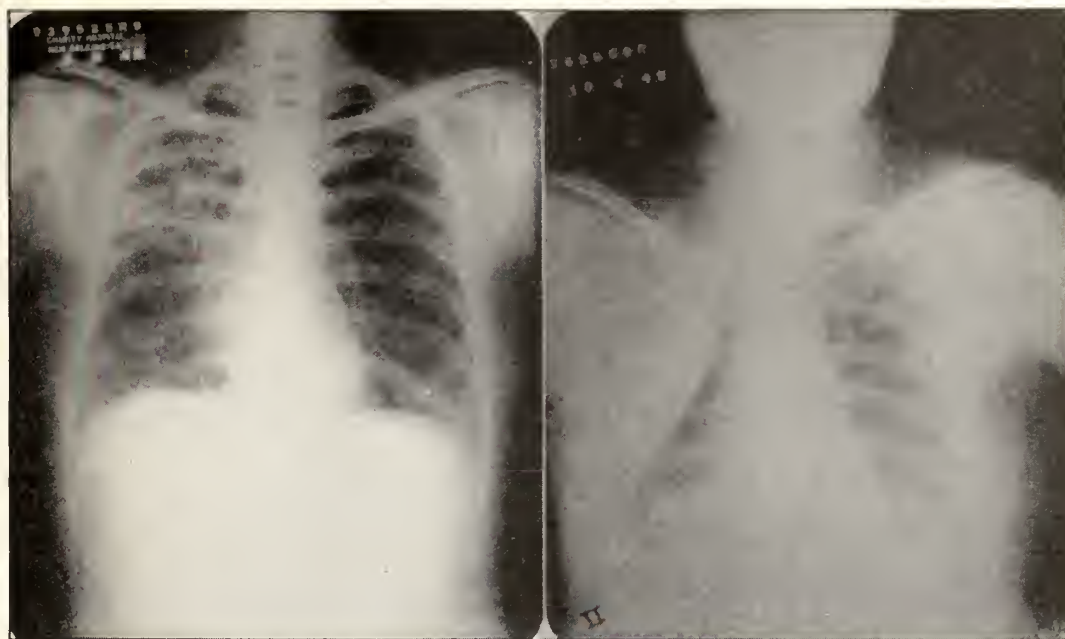
for fibrosis to become well established before beginning artificial pneumothorax; this we found to be a disappointing course of action because usually the tuberculosis continued to progress to the point of the untreatable state. (Case III). We subsequently advocated immediate induction of artificial pneumothorax despite the known and dreaded complications of empyema and the unexpandable lung.¹⁰ Despite the many hazards of collapse therapy, it is absolutely essential for this group of patients. In an attempt to avoid the pitfalls of empyema and the unexpandable lung, a few patients were given streptomycin after establishment of artificial pneumothorax. The preliminary results have been encouraging; streptomycin is effective against the most common single cause of these complications, tuberculous endobronchitis. It is too soon to state that this course should be widely used; an obvious objection is that it may cause the tubercle bacilli to become streptomycin-resistant and accordingly the patient will be denied the benefit of this potent antibiotic if it should be needed later. If the lung cannot be collapsed adequately by pneumothorax, the combination of pneumoperitoneum and phrenic nerve interruption may be used or, in selected instances, (Case IV) thoracoplasty may be performed. In one patient, pneumonectomy was done because of an unexpandable lung following unsuccessful thoracoplasty (Case V).

SUMMARY AND CONCLUSIONS

The patient with uncontrolled diabetes mellitus stands an unusually great risk of developing pulmonary tuberculosis especially after the age of 50 years. His tuberculosis is apt to be ushered in with alarming symptoms and to be in the stage of the far advanced caseous pneumonia when diagnosed. Control of the diabetes is relatively easy with the proper diet and with adequate amounts of insulin. His tuberculosis will require energetic therapy in which bed rest, collapse therapy and antibiotics must be utilized. The prognosis is always grave. Because the incidence of combination of these two diseases will most probably increase in the future, prophylaxis must be exercised. This means the early diagnosis and intensive treatment of all diabetics and—as for all other phases of the campaign to eradicate tuberculosis from the illnesses of man—the periodic examination by means of the x-ray of all available segments of the population.

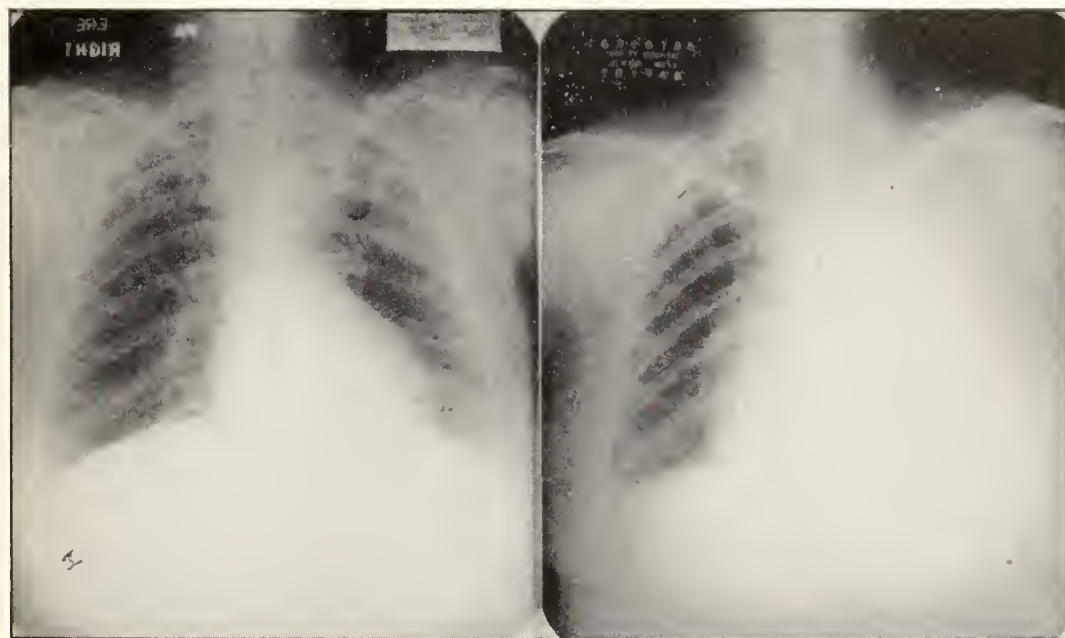
BIBLIOGRAPHY

1. Root, Howard F.: Treatment of Diabetes and Tuberculosis in Treatment of Diabetes Mellitus, by Elliott P. Joslin, Howard F. Root, C. Cabell Bailey, Priscilla White and Alexander Marble. 8th edition. Lea & Febiger, Philadelphia, 1946.



CASE IV — FIGURE IV

S. C., a 56 year old white female, was admitted with diabetes of 6 years duration and tuberculosis discovered after she had a massive hemoptysis 4 months earlier. Pneumothorax was easily induced, but the cavity could not be completely closed. Tuberculous empyema developed, the lung could not be re-expanded, but a three-stage thoracoplasty obliterated the pleural space and accomplished cavity closure.



CASE V — FIGURE V

K. R., a 59 year old white female, discovered in 1941 that she had diabetes mellitus. She was controlled reasonably well until she began to lose weight in July 1947. At that time, tuberculosis was discovered and artificial pneumothorax was induced. After several attempts at pneumonolysis failed to permit closure of a large cavity in the center of a caseous area, pneumonectomy was successfully performed.

2. Steinbach, M. M., and Duca, C. J.: Experimental tuberculosis in hyperglycemic albino rats. *Amer. Rev. Tuberc.* 46:304-308, Sep. '42.
3. Keeton, R. W.: Diabetes and Tuberculosis in B. Goldberg's *Clinical Tuberculosis*. F. A. Davis Company, Philadelphia, 1935.
4. Banyai, A. L., and Cadden, A. V.: The rationale of the therapeutic administration of massive doses of vitamin A in tuberculous diabetics. *Dis. Chest* 10: 133 (Mar) '44.
5. McKean, R. M., Thostenson, G. C., and Brooks, N.: Treatment of tuberculosis and diabetes. *Amer. Rev. Tuberc.* 43:31-41, Jan., '41.
6. Himsforth, H. P.: Pulmonary tuberculosis complicating diabetes mellitus. *Quart. J. Med.* 7:373, 1938.
7. Banyai, A. L., and Cadden, A. V.: Diabetes and tuberculosis. *Arch. Int. Med.* 74: 445, Dec., '44.
8. Rubin, Eli H.: *Diseases of the Chest*. W. B. Saunders, Company, Philadelphia, 1947.
9. Taub, S. J., Sholes, W. H., and Rice, L.: Liver dysfunction hyperglycemia; its etiology and relationship to diabetes mellitus. *Ann. Int. Med.* 22:852, June, '45.
10. Jacobs, Sydney: The Unexpandable lung. *Dis. Chest* 12: 111, Mar. '46.

The Adrenal Medullary Tumor Syndrome (Pheochromocytoma)

CASE REPORT WITH SUCCESSFUL OPERATION

By

JAMES D. NELSON, M. D. AND G. B. HODGE, M. D.
Spartanburg, S. C.

Until recent years a functional tumor of the adrenal medulla was considered an extreme rarity, and usually recognized only on post-mortem examination. To date, around 165 cases of pheochromocytoma have been recorded in the literature. Of this group, only fifty-two have come to operation. Twelve of these patients did not survive surgery, thereby creating a mortality rate of 23%.

The first anatomical and histological description of adrenal medullary tumors was made in 1896. It was not until 1922, that the typical clinical syndrome was first described. In 1929, the first successful surgical removal of an adrenal medullary tumor was carried out.

The case to be presented is not an unusual one, but it is reported in order to reemphasize the usual clinical course of these patients, and to add to the all too small list of such cases.

CASE REPORT

G. R. C. #12527: The patient is a forty-year-old white, married female who was first seen in the office (J. D. N.) on April 16, 1948, and gave a history that she was in excellent health except for an unexplained anemia until three and a half years ago. At that time, ten days after her husband went into the Army, she began experiencing "choking sensations" while singing in the church choir. She noted that with these attacks there was a swelling of the neck in the region of the thyroid gland. Following the attacks the swelling would subside. She also complained of dyspnea, severe throbbing suboccipital

From the Medical and Surgical Services, Spartanburg General Hospital
Spartanburg, S. C.

headaches, nausea, vomiting, and orthopnea. Initially, she was having two to three such attacks daily. She stated that her skin became cold, clammy, and moist and following these seizures she was left with a "run-down feeling."

It was noted that many of these attacks would come on while lying on her back and left side. The patient preferred to lie on her right side. She would sleep on as many as ten pillows on her bed and was much more comfortable sitting up during an attack. She has also noted some pallor and cyanosis of the face and lips and has had precordial pain and palpitation. During the past three and a half years she has had marked constipation.

During the early phase of this patient's illness, her blood pressure was reported to be low; however, two years ago her blood pressure was reported to be around 180 systolic. The above symptoms and findings continued irregularly and had become progressively more severe.

The physical examination at this time revealed a normal temperature, pulse, and respiration. The blood pressure was 178/116. The physical examination was entirely negative. Examination of the urine revealed a 2 plus albumin and on microscopic examination showed six to eight white blood cells per high power field. The hemoglobin was 59%, the red blood count was 4,470,000, and the white blood count was 6,350. The basal metabolic rate was plus 13 and the electrocardiogram was normal.

The first impression was (1) Anemia, undetermined etiology. (2) Hypertension, (3) Possibly climacteric. Symptomatic treatment was prescribed.

The following morning at four a. m. the patient

began having similar attacks to those described above coming on every hour. These attacks were much more severe than any previously experienced and were characterized by circulatory collapse, nausea, vomiting, severe headache and backache with pain radiating from the suboccipital region along the spine to the sacrum. The patient was admitted to the Spartanburg General Hospital on April 17, 1948, at four p. m. and on arrival was found to be in profound shock, cold, clammy, cyanotic, and pulseless. The blood pressure could not be obtained. The patient had a short period of apnea and artificial respiration was administered and one cc. of adrenalin given. Within a few minutes, the blood pressure was over 300 mm. of mercury systolic and 150 mm. of mercury diastolic. Ten minutes later the patient had another attack of circulatory collapse and was given morphine, adrenalin, and oxygen. She improved slightly. A diagnosis of probable adrenal medullary tumor was considered and this impression was concurred in by a surgical consultant (G. B. H.). The general physical examination revealed a normal temperature. The pulse was 160, respiration was 30, and the blood pressure was 80/60. The patient was a well developed, slightly obese, forty-year-old, white female who appeared to be acutely ill and in distress. She was apprehensive.

Skin: Cold, clammy, and moist. The lips were cyanotic and the face had a cadaveric pallor. The hands and dependent parts of the body were livid. There were numerous areas of ecchymosis over the arms at the sites of hypodermic injections.

Glands: There was no local or general lymphadenopathy.

Head: Symmetrical without masses, tenderness or other abnormalities.

Eyes: Cornea, sclera and conjunctiva were clear except for slightly dilated conjunctival vessels. The pupils were contracted but reacted to light and accommodation. Gross vision was good and there was no visual field defect. The optic discs were discrete with normal physiological cupping. There was no AV nicking or venous distension. There were many flame-shaped hemorrhages of recent origin in both eye-grounds.

Ears, Nose, Mouth, and Throat: Negative.

Neck: No cervical rigidity and there were no masses or thyroid enlargement. The trachea was in the midline without deviation or tug.

Chest: Symmetrical and moved bilaterally equal and well with respiration. The breasts were atrophic. There were no masses or tenderness. The left nipple was inverted.

Lungs: Clear to auscultation and percussion.

Heart: Not enlarged. The rate was 160 and the rhythm was regular. There were no murmurs or other abnormalities. The radial pulses were synchronous and the volume was poor.

Abdomen: There was a well healed midline suprapubic scar. The transverse and sigmoid colon were palpated and contained considerable firm fecal material. The aortic pulsations were easily palpable and the liver, spleen, and kidneys were not felt. On palpation in the left flank another attack was precipitated and the patient's blood pressure was found to be 260/160. The remainder of the examination was essentially negative.

The patient's condition was critical. A K U B flat plate of the abdomen revealed the kidneys to be partially visualized. The upper pole of the left kidney was fairly clearly outlined and nothing identifiable as an enlarged suprarenal gland was noted. An x-ray of the chest revealed the heart and aorta to be within normal limits and the diaphragm was smooth. The visualized bones were normal. After a cleansing enema, another K U B flat plate was taken but no additional information could be obtained.

Soon after admission to the hospital a lumbar puncture was carried out. The fluid was clear and under no increased pressure. There were four lymphocytes and the total proteins were 30 mgms. per cent. The spinal fluid serology was negative. The urine revealed albumin one plus and occasional white blood cell per high power field. The hemoglobin was 84% and the white blood count 13,700. The blood sugar was 92 mgms. per cent. The blood chlorides were 793 mgms. per cent and the total proteins were 5.6 gms. per cent. An intravenous pyelogram was contemplated, however the patient had a severe attack in the X-ray Department and had to be returned to the ward before the test could be carried out. The patient was placed on a high carbohydrate diet, sedation, and 5 mgms. of desoxycorticosterone daily. On the seventh hospital day the patient had shown signs of marked improvement and the attacks were less severe. It was felt that the other diagnostic studies which were indicated were inadvisable in view of the patient's precarious condition. It was decided to carry out an exploratory laparotomy and this was done on April 26, 1948.

The operation was carried out under cyclopropane and curare anesthesia. The abdomen was entered through a transverse incision which extended from the left flank to the right flank. The left adrenal gland was exposed and found to be normal in appearance, however, it was about three times normal in size. There was no suprarenal tumor on the left side. The right kidney was found to be lying low and overlying the right kidney a large tumor mass was encountered which measured 7 x 8 cm. in diameter. After the blood supply had been isolated and controlled by ligatures, the tumor mass was removed. The systolic blood pressure was 240 mm. just before the tumor was removed, and immediately following the removal of the tumor, the blood pressure dropped to 40 mm. systolic. Neosynephrine was given intravenously with the prompt return of the blood pressure to 100. The abdomen was then closed in layers using a con-

tinnous 0 chromic catgut suture for the peritoneum and posterior rectus sheath and interrupted silk sutures for the anterior rectus sheath and fascia. The subcutaneous tissue and skin were closed with interrupted fine black silk sutures. The patient received 1000 cc. of citrated blood during the operation and was returned to the ward in satisfactory condition.

Following the operation, she was given 2000 cc. of 5% glucose in saline and 1000 cc. of normal saline intravenously. The day of operation the patient received 5 mgms. of Desoxycorticosterone and during the first twelve hours the patient was given adrenalin when the blood pressure dropped below 100. The blood pressure stabilized around 100/70 in 48 hours and the patient's postoperative recovery was rather smooth and uneventful. She was discharged from the hospital on May 5, 1948.

The pathological diagnosis was benign pheochromocytoma of the right adrenal gland. The follow-up three months later revealed the patient to be in excellent health, entirely free of complaints, and with the blood pressure 104/78.

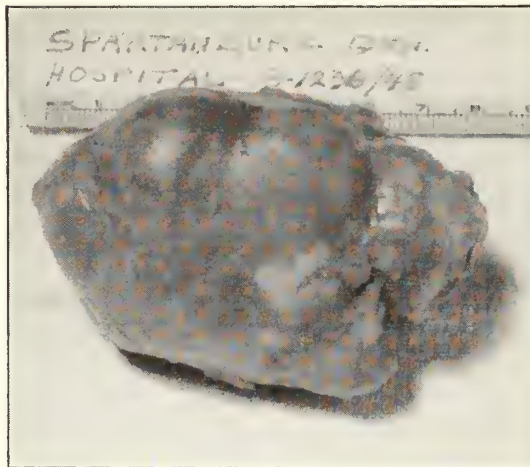


Figure I—Photograph of gross specimen. The tumor is encapsulated and weighs 76 grams. It is 8 cms. in greatest diameter.

DISCUSSION

The diagnosis of functioning adrenal medullary tumors is being made with increasing frequency due to the renewed interest in the surgical management of hypertension.

In any patient with a history or findings of paroxysmal hypertension, an adrenal medullary tumor should be suspected. Recently there have been reports¹ of sustained hypertension due to functioning adrenal medullary tumors. Every diagnostic survey in patients with essential hypertension must include studies to rule out the possibility of an underlying pheochromocytoma as a cause. In addition to the history, which is classical, and physical findings, there

are a number of studies that are of value diagnostically.

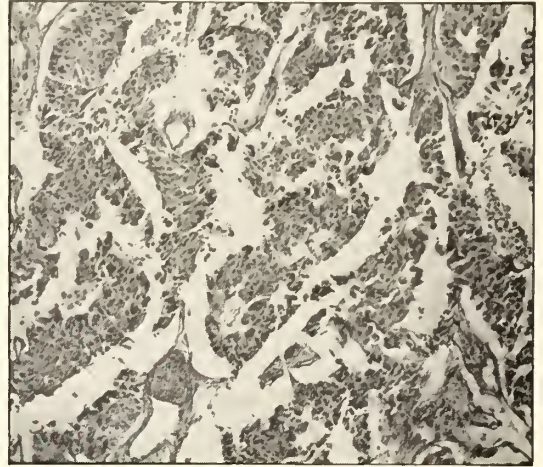
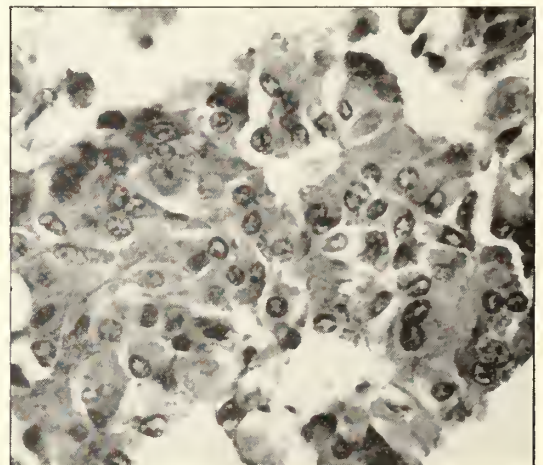


Figure II—(A) Low power photomicrograph revealing the typical alveolar-like arrangement of the cells which are separated by a delicate stroma.

These patients are extremely sensitive to adrenalin and the administration of the usual test dose of adrenalin will precipitate a hypertensive crisis in these patients far out of proportion to that encountered in a normal individual. In a patient having a typical hypertensive crisis a blood adrenalin level will reveal an abnormal amount of circulating hormone. However, this test requires a great deal of technical and physical equipment and is not feasible except in certain centers where those facilities are available.

Histamine has been employed and shown to have a characteristic response in patients with adrenal medullary tumors. Five-tenths of a milligram of hista-



(B) High power photomicrograph. The cells are polygonal and quite large and contain a vesicular nucleus. The cytoplasm has a fine granular appearance. There is no evidence of malignancy.

mine phosphate administered subcutaneously will precipitate a severe hypertensive crisis. This has been described by Hyman and Mencher² and Roth and Kvale³ and more recently, by Burrage and Halstead.⁴ Histamine causes an increased output of adrenalin from the adrenal medulla. Roth and Kvale⁵ have demonstrated in three cases of proven pheochromocytoma the efficacy of this test.

The insulin test also has some diagnostic significance in that it will produce a severe hypoglycemic reaction and hypertensive crisis.

More recently, Ganem and Cahill⁶ have employed Piperidino-methyl-benzodioxane in a patient with a pheochromocytoma. Benzodioxane has an anti-adrenalin action. In 1934, de Vleeschhouwer⁷ showed that benzodioxane reverses the hypertension produced by adrenalin in dogs. In normal individuals the administration of this drug causes very little change in the blood pressure. However, in patients with hyperadrenalinemia there is a definite lowering of the blood pressure.

Another diagnostic procedure combining histamine and benzodioxane may be used. The administration of histamine as mentioned above produces a severe hypertensive crisis and this crisis may be blocked by the administration of benzodioxane.

Blood sugar determinations before and during an attack usually reveal a hyperglycemic reaction during the attack. Recently, Duncan, Semans, and Howard⁸ reported a case of pheochromocytoma with diabetes mellitus. Following surgical removal of the tumor the diabetic condition was relieved.

The blood sodium and potassium levels usually reveal an elevation of these electrolytes.

Intravenous pyclography in the vast majority of cases will reveal some displacement of the kidney on the side of the lesion, and occasionally one may be able to see a suprarenal mass on a routine K U B flat plate of the abdomen. Perirenal air insufflation has been advocated as a diagnostic procedure. However, it is not without some risk.

Approximately 15% of these tumors are bilateral, and occasionally they are found in the thorax and in the pelvis. There are a few reports of malignant pheochromocytomas.

Bioassays have shown that there is approximately 8 mgms. of adrenalin in one gram of adrenal medullary tumor tissue. The normal adrenal gland contains around three-fourths of a mgm. of adrenalin per gram of adrenal medullary tissue.

The case reported here had a tumor weighing 76 grams and on the above estimation, the tumor should contain around 608 mgms. of adrenalin.

CONCLUSION & SUMMARY

In any patient with a history and findings of paroxysmal hypertension or an unexplained persistent hypertension, an adrenal medullary tumor must be considered. Various diagnostic procedures have been outlined. The literature has been briefly referred to. The case of a forty-year-old female having attacks of severe, throbbing, suboccipital headaches, nausea, vomiting, cold, clammy, moist skin, pallor, cyanosis, palpitation, dyspnea, and orthopnea with paroxysmal hypertension is reported. At operation the patient was found to have a pheochromocytoma weighing 76 gms. A successful surgical removal and recovery of the patient was obtained.

BIBLIOGRAPHY

- (1) Thorne, G. W., Hindle, J. A., and Sandmeyer, J. A., "Pheochromocytoma of The Adrenal Associated With Persistent Hypertension", *Annals Internal Medicine*, 1944, XX, 815.
- (2) Hyman, A., and Mencher, W. H., "Pheochromocytoma of Adrenal Gland", *Journal Urology*, 1943, XLIX, 755.
- (3) Roth, G. M., and Kvale, W. F., "A Tentative Test for the Diagnosis of Pheochromocytoma", *Proceedings Central Society Clinical Research*, 1944, xvii, 18.
- (4) Burrage, W. C., and Halstead, J. A., "Adrenal Medullary Tumor (Pheochromocytoma); Case Report with Successful Operation", *Annals of Internal Medicine*, 1948, xxxii, 838.
- (5) Roth, G. M., and Kvale, W. F., "A Tentative Test for Pheochromocytoma", *American Journal of the Medical Sciences*, 1945, ccx, 653.
- (6) Ganem, E. J., and Cahill, G. F., "Pheochromocytomas Coexisting In Adrenal Gland and Retroperitoneal Space, With Sustained Hypertension", *The New England Journal of Medicine*, 1948, ccxxxviii, 692.
- (7) de Vleeschhouwer, G., "Influence d'un nouveau au dérivé de la dioxane sur les réflexes vasomoteurs et sur l'hypertension adrénalique et nicotinique", *Compt. rend. Soc. de biol.*, 1934, cxv, 1247.
- (8) Duncan, L. E., Jr., Semans, J. H., and Howard, J. E., "Adrenal Medullary Tumor (Pheochromocytoma) and Diabetes Mellitus: Disappearance of Diabetes After Removal of Tumor", *Annals of Internal Medicine*, 1944, xx, 815.

Peritoneoscopy

CHARLES BUNCH, M. D., F.A.C.S.
Charlotte, N. C.

Peritoneoscopy has a definite and valuable place in the diagnosis of abdominal disease. It is useful too in determining the extent of involvement of a pathological process in the abdomen.

The procedure dates back to 1901 when Keeling inflated an animal's abdomen with air and examined the contents with a cystoscope. However, it was not until 1934 that Ruddock devised the present instrument and outlined the procedure, introducing the term "Peritoneoscopy". He also in 1937 developed a suitable instrument for taking an adequate and safe biopsy.

This opened up an entirely new field in the diagnosis of intra-abdominal disease. Much of the abdomen could be carefully visualized and a sizable specimen of diseased tissue could actually be placed under the microscope by this minor diagnostic procedure.

Peritoneoscopy has certain indications, limitations, and advantages.

The procedure is indicated in all cases of ascites of indefinite origin. These patients receive the benefit not only of paracentesis but a definite diagnosis is established by both inspection and by biopsy. Cases of cirrhosis of whatever type, abdominal carcinomatosis, gastric or pelvic malignancy, and tuberculous peritonitis can readily be diagnosed. Abdominal masses such as cysts, enlarged viscus, or abscesses may be inspected. Known malignancies, such as carcinoma of the stomach or colon, can be visualized and valuable information obtained regarding the lesions resectability. In known cases of sub-diaphragmatic abscess careful peritoneoscopy might be of aid in determining at what area the abscess can best be drained surgically. Pelvic pathology in the female can be studied: ectopic gestation, ovarian cysts, as well as other pelvic lesions.

Peritoneoscopic limitations are from a diagnostic standpoint, anatomical. Certain abdominal organs can usually be seen, certain ones occasionally seen, and others never seen through the instrument at all.

In the first group, those usually seen are: part of edges and a portion of the lower surface of both lobes of the liver; most of the gall bladder; the anterior wall and the greater curvature of the stomach; some of the omentum; a portion of the small intestine; cecum, ascending, transverse and descending colon to the upper sigmoid; dome and posterior surface of the bladder; and the parietal peritoneum.

Structures that are occasionally seen, or may be seen with the aid of manipulation, are: part of the spleen; appendix, (over 60% are retrocecal and can-

not be seen), and terminal ileum; the uterus, ovaries and tubes (aided by manipulation through vagina); and the pelvic colon.

Structures that are never seen are: the posterior wall of the stomach; most of the duodenum; the deep biliary structures; pancreas; kidneys adrenals; most of the mesentery; and the great vessels.

Certain individual factors also limit the procedure. These are extensive adhesions, tubercular peritonitis, and extreme obesity, etc.

Peritoneoscopy should not be used in therapy. It is not suitable to sever abdominal adhesions nor should it be used to sever or cauterize a tube to produce sterility. Paracentesis however, is carried out in cases of ascites.

Peritoneoscopy has several distinct advantages. It is a readily available procedure in establishing a definite diagnosis in many cases of indefinite abdominal disease. It is a minor procedure and can most often be carried out under local anesthesia and sedation, or under a light sodium pentothal anesthesia, requiring only a day or at the most two days of hospitalization. The procedure often saves the patient a laparotomy with its increased expense, discomfort and longer hospitalization. Also from an economic standpoint it will often make unnecessary a lot of x-ray and laboratory procedures.

The technique of peritoneoscopy will not be described here. Those interested need only to refer to that excellent article by Ruddock that appeared in 1937. As experience with peritoneoscopy increases, the need for biopsy of the lesion decreases; for in most cases the diagnosis can be made by inspection alone. A thorough knowledge of gross pathology and altered physiology is essential; and the macroscopic appearance of living tissue is quite distinctive and differs considerably from their appearance in the cadaver. It is best to make a thorough inspection through the observation 'scope before any attempt is made at biopsy.

The contra-indications of the procedure are few. It should never be done in acute peritonitis. In distention there is danger of bowel perforation. Known adhesions from previous inflammation and surgery is not an absolute contra-indication.

The dangers likewise are few, namely hemorrhage and perforation. In a series of cases I have encountered neither. The hemorrhage from the biopsy is usually small and can be controlled by electrocoagulation. Perforation of the bowel should be recognized and treated by immediate laparotomy

and repair. The mortality rate from peritoneoscopy as reported over the country is almost nil, and in my small series the mortality rate is zero.

Peritoneoscopy is an established, safe, brief and minor diagnostic procedure. Although it has certain limitations, it has distinct advantages. Its economic advantages in certain cases is emphasized. It is purely for diagnosis and although it may save a patient a laparotomy it is not intended to take the place of laparotomy.

BIBLIOGRAPHY

1. Keeling, George. Ueber Oesophagoskopie, Gastroskopie and Koelioskopie. Read before the 73rd Versamml. Deutsch. Naturforscher und aerzte, Hamburg, September 23, 1901. Muenchen, med. Wchnschr., Page 21 (Jan. 7) 1902.
2. Ruddock, John C. Peritoneoscopy, Western J. Surg., 42:392, July 1934.
3. Ruddock, John C. Peritoneoscopy. Surg. Gynec., and Obst. 65:623, (Nov.) 1937.

SOUTH CAROLINA MEDICAL ASSOCIATION

BALANCE SHEET

December 31, 1948

ASSETS

Petty Cash	\$	10.00
Guaranty Bank and Trust Company		17,148.33
Accounts Receivable		1,058.41
Deposits Receivable		3.00
Investments		
Defense Bonds	\$10,000.00	
Peoples Federal and Saving	5,000.00	15,000.00
		<hr/>
Office Furniture and Fixtures		2,200.71
		<hr/>
Total Assets		\$35,420.45

LIABILITIES

Social Security	15.25
Withholding Taxes	282.30
	<hr/>
Total Liabilities	297.55

SURPLUS

Balance	32,115.93
Excess of Revenue over Expense	3,006.97
	<hr/>
Total Surplus	35,122.90
	<hr/>
Total Liabilities and Surplus	\$35,420.45

We have examined the treasurer's records of the South Carolina Medical Association for the year ended December 31, 1948, and,

We certify that in our opinion the above Balance Sheet and accompanying Statement of Revenue and Expense set forth the financial condition of the South Carolina Medical Association as at December 31, 1948, and the results of its income and expense for the year ended on that date.

Respectfully submitted,

JAILLETTE & BRUNSON
Public Accountants

Florence, South Carolina
January 20, 1949

SOUTH CAROLINA MEDICAL ASSOCIATION

STATEMENT OF REVENUE AND EXPENSE

January 1, 1948 to December 31, 1948

Revenue

Membership Dues	\$17,017.00	
Subscription Dues	3,048.00	
Advertising	10,404.75	
Interest Earned	206.25	
Miscellaneous Income	2,324.15	
Exhibits	3,265.50	
Directory of Membership	30.50	
Gross Revenue		\$36,296.15

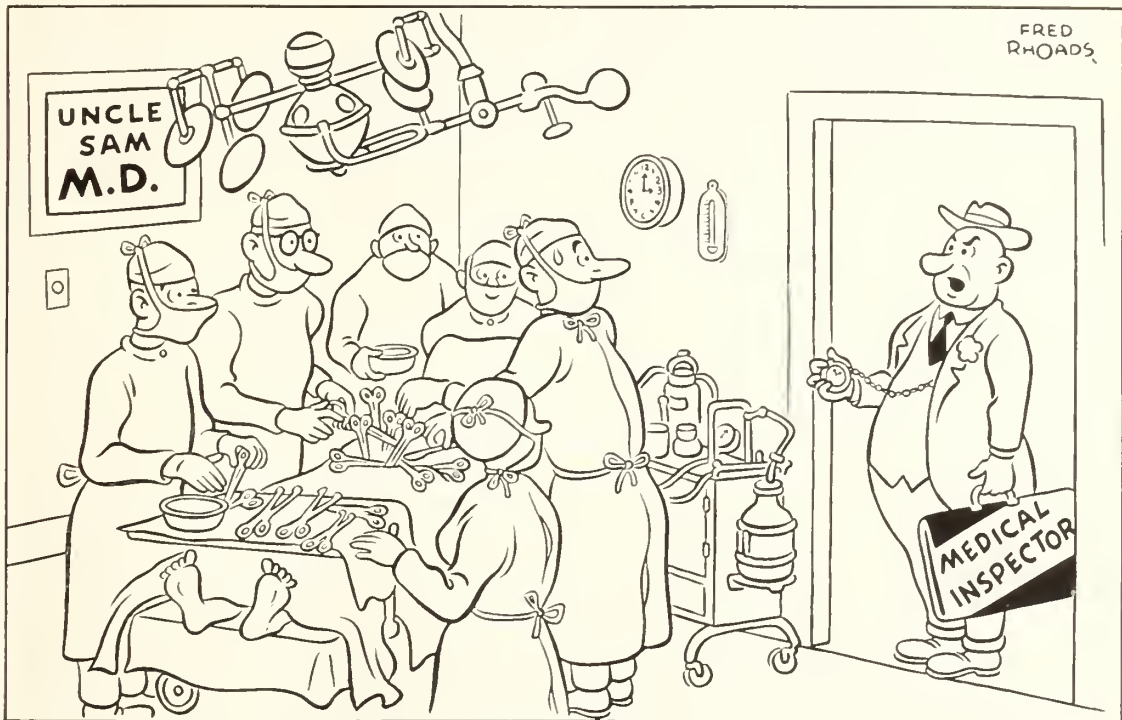
Less: Expense

Audit and Legal	85.75	
A. M. A. Convention	704.34	
Bank Charges	4.90	
Dues and Subscription	63.00	
Emblems	39.00	
Express and Drayage	5.12	
Expense—Director of Public Relations	1,381.77	
Heat, Light and Water	93.94	
Insurance	49.60	
National Conference	925.55	
Miscellaneous Expense	952.58	
Membership Roster	466.56	
Office Supplies	1,192.39	
Printing Journals	5,918.27	
Postage	165.50	
Rent	606.00	
Salary—Secretary and Editor	3,000.00	
Salary—Director of Public Relations	7,000.00	
Salary—Business Manager	1,450.00	
Salary—Stenographer	1,825.00	
Stenographic Help	113.00	
*S. C. Conventions	6,444.26	
Taxes	105.00	
Telephone	594.75	
Traveling	117.50	
Total Expenses		33,303.78
Excess of Revenue over Expense		2,992.37

Other Income

Miscellaneous	14.60
Excess of Revenue over Expense	\$ 3,006.97

*(This includes an item of \$2,549.95 for printing "A Brief History of the S. C. Med. Assoc.")



"BETTER CUT IT SHORT, DOC, YOUR OFFICE HOURS BEGIN AT THREE"

ANNUAL MEETING

MAY 17, 18, 19

MYRTLE BEACH

The Journal of the South Carolina Medical Association

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)
Subscription Price

Florence, S. C.
\$3.00 per Year

MARCH, 1949

CONGRATULATIONS AND THANK YOU

Physicians are not only men of medicine but are also citizens and leaders in their respective communities. To prove this assertion we wish to recount the honor which has come to three of our members and to join with their many friends in extending our sincere congratulations.

Dr. Wm. L. Byerly of Hartsville was recently presented the annual award of "Man of the Year" of his community. In making the presentation, Dr. D. C. Agnew, President of the Rotary Club and of Coker College, described the recipient as having "served this community and its outreaching areas with high honor and credit to his profession."

Dr. M. J. Boggs of Abbeville was given the Man of the Year award of the Junior Chamber of Commerce of Abbeville and was thus designated as the young man who had done most for his community during the past year.

Dr. W. W. Bauer was selected as the Man of the Year by the Hemingway Junior Chamber of Commerce.

To these three men, Drs. Byerly, Boggs, and Bauer, we say, "Thank you for the honor which you have brought to our profession and for the service which you have rendered to your communities."

HOUSE OF DELEGATES

The coming annual meeting of the House of Delegates on May 17 will be a highly important one. Many matters will be up for discussion and some far reaching decisions will probably be made.

One of the most important matters to be considered will be the report of the Committee on Medical Service, Dr. J. D. Guess, Chairman. This Committee is recommending the creation of a Medical Service (Blue Shield) Plan by our Association. Details of the proposed plan will be printed in the Journal and all delegates are asked to read them carefully.

With the strong fight being waged for Oscar

Ewing's Health Plan with its compulsory health insurance, reports of our activities along this line will be presented and plans will be made for further action.

In addition to the regular election of officers, other important elections are coming up. The terms of the present medical members of the Executive Committee of the State Board of Health expire this year. The terms of three members of our Council expire this year, as do members on the State Board of Medical Examiners and State Board of Registration of Nurses. We are now entitled to two delegates to the House of Delegates of the A. M. A. Our second delegate will be elected at our annual meeting and will take office on Jan. 1, 1950.

These are but some of the decisions which must be reached by our House of Delegates. All in all, it appears that those who attend are in for a busy session.

IN ENGLAND

Burnet R. Davis, M. D., (U.S.P.H.) has recently prepared a factual study of medical practice as it is now being carried on in England. It is not possible to print his entire report but we are presenting extracts which should give a general idea of how socialized medicine is being conducted in that country.

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"The National Health Service came into operation in Great Britain on the "appointed day," July 5, 1948.

"For more than half of the adult population the method of obtaining family doctor services remains virtually unchanged. Since 1912 nearly all employed adults have been covered under National Health Insurance for this portion of their medical care. The arrangements are very simple for the consumer: He selects a doctor from the local list of those who have agreed to participate, fills out an application form and gives it to the doctor chosen. From then on he is eligible to receive general practitioner care from that doctor, or from any other participating doctor in an emergency or when away from home. He may change to another doctor by giving written notice. He visits

or is visited by his general practitioner for all general care required, but pays no fees. All members of a family do not necessarily select the same doctor, although children under 16 have theirs chosen by their parents.

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"Everyone, is entitled to hospital care without charge, and it is certain that only a relatively small fraction of the population will elect to pay for private care. The portion of the public most conscious of the change, perhaps, is the middle-class group which has been ineligible for free care in voluntary hospitals but has found the cost even in municipal hospitals very burdensome.

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"Except for the private consulting practice serving the upper income groups, specialist care in England has been rendered chiefly through hospital in-and-out-patient service. Now that specialists are paid from public funds, it is expected that specialist care will be available to many persons who have not had access to it in the past. Arrangements for specialist and hospital care are made by the general practitioner when he deems such care necessary.

"Prescription drugs are furnished without charge as a part of the general practitioner service. Eyeglasses and necessary appliances such as hearing aids and artificial limbs are provided also, through appropriate medical channels.

"Preventive public health services continue in the new service to be provided by local health departments, although the patient may now ask for some of these personal services from his family doctor.

"Nursing in the home is now furnished without charge, to an extent limited by available staff.

"Ambulance and other transportation necessitated by illness is also included.

"A person seeking dental care must find a dentist willing to undertake the required work, and the dentist's fee is paid from public funds at no cost to the patient unless he elects to have more expensive types of fillings or dentures than are required on clinical grounds.

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"The new service will greatly decrease the amount of private fee-earning work but will increase payments to doctors from public funds. The general effect will be to decrease the variation in, but by no means equalize, general practitioners incomes, because the doctor receives his pay on a Capitation basis—that is, a fixed amount per quarter per person on his list. The extent to which the individual doctor will feel the change will depend on his type of practice. In industrial areas, the private patients a doctor will lose will be mostly dependents of wage earners, who were able to pay little in the past. In return, he will gain payment on behalf of these patients from public funds. In wealthier neighborhoods, some doctors will

find that their loss of private fees is not fully replaced by income from the public service.

"Doctors are concerned not only with remuneration. There is also fear that free service will increase the practitioner's patient load, perhaps to an extent not consistent with a good standard of medical care. Since many doctors were overworked before July 5, this fear is not without foundation.

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"What will be the effect on a doctor's freedom to practice where and as he chooses? Doctors in practice on the appointed day have a statutory right to continue where they are. Those entering practice for the first time, or changing their location after the appointed day do so subject to the approval of the Medical Practices Committee, seven of whose nine members are medical. Only if the number of practitioners in an area is already adequate, however, may the Committee refuse to admit a doctor to that area. Since at present very few areas in England are "over-doctored," it is expected that this power of "negative direction" will only rarely be exercised. Usually doctors will move to fill vacancies caused by death or retirement, just as they have done in the past.

"The terms of service to which participating general practitioners must subscribe, the method of payment, and arrangements for handling complaints and discipline are virtually unchanged from the old system, so that doctors who have had insurance patients in the past will find little that is unfamiliar in administrative procedures. Perhaps the most fundamental difference is that there will now be little medical work outside the public service; thus a doctor who does not wish to participate may find difficulty in making a living unless he is exceptionally well established. In these circumstances it is very important that the doctors have a strong professional organization with long experience in negotiating with the government, and that they are well represented in the various administrative and advisory bodies concerned with the health service.

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"The introduction of the new service will undoubtedly increase the work load of hospitals. Persons who have postponed elective surgery, for example, because of its cost, are now eligible for surgical care free of charge. Moreover, some general practitioners, no longer having a direct financial interest in continued treatment of their patients may tend to refer them more freely to hospitals for out-patient specialist care or in-patient study and treatment. The most critical problem of overload is feared in the care of the chronic sick, since institutions for this type of case were already full before the appointed day, and there will now be much pressure for admission of patients cared for under difficulties in the home.

The problem of overloaded hospitals is the more serious because of the very small amount of new hos-

pital building which can be undertaken in the near future, and critical shortage of staff, especially nurses. Because of these staff shortages many hospital beds were out of operation before the appointed day.

Although the increased pressure for hospitalization will create many problems for hospital administrators and professional staff, the service will introduce other factors which may result in more effective utilization of the admittedly limited facilities. With removal of financial barriers and geographical eligibility requirements it should be possible to admit patients to hospitals on the basis of medical need, thus increasing the usefulness of hospitals.

* * * * *

"Specialists, from the standpoint of the purely professional aspects of their work, will find little change under the new service. They will continue to do most of their work in hospitals and out-patient clinics, seeing patients referred by general practitioners. Some individuals may be asked to concentrate their work in a smaller number of hospitals than in the past, and some may be asked to visit hospitals which have not heretofore had adequate coverage. These efforts toward rationalizing the use of specialists will necessarily come gradually, as the needs become apparent to the boards and committees responsible for administration of the hospital and specialist service.

"Financially, specialists will find many changes. Their pay from hospitals in the past has varied from the traditional free service to substantial sessional or operative fees. A few municipal hospitals have been staffed with whole-time salaried specialists, but the commoner practice of municipal hospitals has been payment on a sessional basis. Voluntary hospitals have been slower to adopt any scheme of payment, although during the recent war the central government began paying specialists for services rendered to hospital patients under the Emergency Medical Service (for civilian casualties, evacuees, etc.). Under the new arrangements, all specialists will receive payment, in accordance with nationally negotiated scales of payment and terms of service, for the public work they undertake.

"It seems likely that private work will decline to an extent which may mean net loss of income to many specialists. On the other hand, the median income of specialists will be increased, chiefly because of equalization of scales among the several specialties.

* * * * *

"The act sets up, as advisory to the Minister, a central health services council, with 41 members drawn from the medical, dental, nursing, midwifery, and pharmaceutical professions, and from persons with experience in hospital management, mental health services, and local government health services, under part III; and the general medical, dental, and pharmaceutical services under part IV.

* * * * *

"Under part II of the act, all voluntary (nonprofit)

and public hospitals and their equipment became central government property on the appointed day, but their administration is decentralized. There are 14 regions, each containing a university medical school and following so far as possible natural hospitalization boundaries. The regions differ greatly in geographical area and vary in population from about 1½ to 4½ million.

"A regional hospital board, appointed by the Minister, administers the hospital and specialist services of each region. The board's primary function is to see that the facilities and services are planned on a regional basis, whereas the day-to-day detailed management of the hospitals is under hospital management committees appointed by the board. For example, the board is responsible for the senior specialist staff, which must be organized on a regional basis if the needs of one hospital are to be balanced against those of another. The local management committees are responsible for appointment of resident medical staff, nurses, and other employees, for admission procedures, and for housekeeping and maintenance operations.

"The hospital management committees are appointed by the boards, after consultation with the local professional and other groups concerned. Their size is variable, being generally between 15 and 20 members. In appointing these committees, the boards have drawn heavily on the membership of the governing bodies of voluntary and public hospitals, but the groups concerned with public health and general practitioner services are represented as well.

"The number and size of hospitals grouped under the management of each committee vary greatly. The object is to group functionally related units so that they can be administered jointly as a general hospital. For example, two moderate sized general hospitals, a maternity home, a children's hospital, an isolation unit, and a tuberculosis sanatorium located in a single large town might be under one committee. Small general practitioner ("cottage") hospitals are usually included in groups containing larger specialist-staffed general hospitals. Mental hospitals are generally grouped together, or, as is often the case, an individual mental hospital is large enough to justify its own committee. A figure of 1,000 beds has been used as a general guide to groupings, but wide deviations above and below this figure result from geographic and other special situations.

"In recognition of the special functions of university medical and dental teaching hospitals, the act places their administration under boards of governors rather than under the regional hospital boards. Each board of governors is responsible for a functionally associated group of hospitals designated by the Minister, after consultation with the university. The boards are appointed by and responsible directly to the Minister.

"The act gives the Minister of Health broad power to conduct or assist any person to conduct research into matters relating to causes, diagnosis, treatment, or prevention of disease. In addition, boards of governors, regional hospital boards, and hospital management committees are authorized to conduct research. These powers supplement those of the Medical Research Council, which for many years has been a Coordinating body for research in the medical sciences.

"Local administration is carried out by the executive council, a statutory body set up for each local health authority area. This body has 25 members, of whom 12 are appointed by representatives of the professional groups taking part in the service, 5 are appointed by the Minister, and 8 by the local health authority. Members of the council serve without pay on a voluntary basis, but a paid staff is employed to carry on its routine business.

"The executive council contracts with medical and dental practitioners and pharmacists who wish to participate in the service. Public lists are maintained of these practitioners. Each medical practitioner is responsible for the patients who choose and are accepted by him, and the number of such persons is the basis for the major portion of the doctor's pay. The council must therefore keep a current record of the persons on each doctor's list. The doctor notifies the council of deaths, and newborn infants are added to a doctor's list at the request of the parent. Machinery is also set up for keeping track of transfers from one doctor to another both within and outside each council's area. The administrative procedures and records required are greatly simplified by two facts: all persons are eligible for service, and payment to doctors is made on a capitation basis.

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"Under the act, doctors are entitled to accept or refuse any patient, but provision is made for patients who cannot find a doctor willing to accept them. The council is empowered to assign such a person to a practitioner, though experience under National Health Insurance suggests that this power will only rarely have to be exercised.

"The practitioner is responsible for proper and necessary treatment of patients whom he has accepted, or whom he may be called upon to treat in an emergency, provided that the treatment does not involve the application of special skill or experience of a kind or degree which general practitioners as a class cannot reasonably be expected to possess. If the patient needs treatment of specialist character, the practitioner is expected to advise and assist the patient in obtaining hospital and specialist care.

"The practitioner is required to hold regular office hours, to provide proper office accommodation, and to visit patients in their homes when medically neces-

sary. He must supply drugs needed for immediate administration, and prescribe other drugs and appliances to be obtained from a pharmacist. He is required to issue without charge any certificate reasonably required by a patient "for the purpose of any enactment," for example, a disability certificate required for social security benefit. Provision is made for consultation with a medical officer of the Ministry of Health on questions regarding certification.

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"Three types of disciplinary action may be taken against a practitioner: imposition of a special limit on the size of his list, monetary fines, and removal from the council's list, which prevents his participating in the service.

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"Remuneration of general practitioners—The act does not specify the amount or methods of payment of doctors, and even the regulations do not give full details.

"A central fund is set up on the basis of 18 shillings per head for 95 percent of the population, on the assumption that about this proportion will eventually use the service. A deduction is made for the mileage fund, and the balance of the fund is distributed to the local executive councils in accordance with a formula which adjusts for persons not yet enrolled on a doctor's list, but who will enroll when they become ill. This formula distributes the fund in proportion to the number of persons actually on doctor's lists plus one-third of those not on lists in each executive council area. Thus a definite amount is allocated quarterly to each executive council, out of which all payments (except mileage) to general practitioners must be made. From this amount deductions are made for payment for emergency treatments, temporary residents, anesthetics, and fixed annual payments, and the balance is distributed among the doctors in proportion to the numbers of persons on the list of each. The actual capitation fee payable to the doctor per person on his list will vary from area to area, depending on the proportion of people enrolled in the area and on the relative amount of noneapitation payments required in the area.

"Special payments for "mileage" are made from a central mileage fund (deducted from the total 18-shilling pool) which is distributed to rural and semi-rural council areas on the basis of their geographical characteristics, and to individual doctors in proportion to points scored for patients residing varying distances over two miles from his office. The mileage payment is thus analogous to the capitation fee in that it is fixed in relation to the patients for whom the doctor is responsible and unrelated to the actual number of visits made to distant patients.

"The fixed annual payment of 300 pounds, originally proposed for all practitioners, will now be made only to those applying for it and showing

justification for it; e. g., young doctors starting in practice, or elderly doctors able to carry only a small load. Since these payments come out of the local pool, the capitation fee is reduced in an area as the number of fixed payments increases. The doctor receiving the payment has the number of patients on his list reduced by one-seventh in computing his capitation payment. Thus the effect of the fixed payment is to increase the pay of the doctor with a small list, whereas the doctor with a large list would receive more pay without the fixed payment and would not apply for it.

"Payment for emergency treatments and anesthesia is made on a fee-for-service basis out of executive council funds, whereas payment for "temporary residents" is a capitation fee adjusted to allow for the fact that persons away from home for periods of under 3 months are unlikely to enroll with a doctor until they actually need treatment.

"A special fund is set up centrally (in addition to the central pool) to be used for inducement payments for practitioners in areas with insufficient doctors, especially where low population density will make doctors' lists too small to permit adequate income otherwise. This fund will be equivalent to 1 percent of the central pool. Special payments will also be made to selected practitioners who undertake to train assistants.

"Maternity service is not included in the capitation fee and extra payments are made for each case for which the doctor accepts professional responsibility, whether or not he is actually called to the confinement by the midwife.

"General practitioners are included in the "super-annuation," or pension plan, which covers all health service personnel. There is a compulsory deduction of 6 percent of the practitioner's "net" income, to which is added a contribution of 8 percent by the government. From the fund thus created retirement benefits, including widow's pension, are paid. The government contribution in effect adds about 5 percent to the doctor's gross remuneration from public funds."

MEETING OF COUNCIL, JANUARY 16, 1949

Council met on the afternoon of January 16, three p. m., Columbia, S. C.

Present: Drs. Mayer, Durham, McCants, Macdonald, Sease, Thackston, Smith, Baker Chapman, Stokes, Price and Mr. M. L. Meadors. Also present on invitation were: Drs. Heyward, Wyman, Chamberlain, Bozard, N. O. Eaddy, and W. A. Hart.

Mr. Caldwell Withers, Public Relations Executive, submitted a proposal, at the request of Council, for a general public relations program for the S. C. M. A. This was referred to the Committee on Public Relations which was present. This committee retired for consideration and then recommended that Council

thank Mr. Withers for the proposal and inform him that we did not think it wise to embark upon such an extensive program at the present time. The committee also recommended that Mr. M. L. Meadors be instructed to enlarge his office staff and activities in the field of public relations and that the treasurer be instructed to expend up to an additional \$5,000.00 during this fiscal year for such. This recommendation was approved.

Dr. Ben Wyman presented a plan for a heart demonstration program of follow-up and rehabilitation of cardiac cases which was to be financed by the United States Public Health Service and operated by the South Carolina State Board of Health—such program to be subject to the approval of the County Medical Society and the County Health Department in that county in which it was instituted. Council approved the plan in principle.

A letter was read from the president of the Palmetto Medical, Dental and Pharmaceutical Association asking for one representative on the Hospital Advisory Committee to the State Board of Health. Council discussed this fully and passed a resolution recommending to the House of Delegates at its next annual meeting that such an appointment be made.

The Report of the Committee on Medical Service was presented by Dr. J. H. Stokes, Vice Chairman, in the absence of Dr. J. D. Guess, Chairman. The proposed by-laws were presented item by item and discussed. The committee was instructed to present these amended by-laws to the House of Delegates at the next annual session. Council then elected the following individuals to serve as the tentative medical members of the proposed board of directors for a Surgical and Obstetrical Service Plan: Drs. J. D. Guess, Chairman, Greenville (obstetrics); J. H. Stokes, Florence (EENT); G. D. Johnson, Spartanburg (pediatrics); Wyman King, Batesburg (general practice); C. R. F. Baker, Sumter (surgery); A. C. Bozard, Manning (general practice); John Siegling, Charleston (orthopedics); W. T. Barron, Columbia (urology). This group was instructed to meet and to present the nominations for membership on the proposed Board of non-medical members, to a meeting of Council on February 14.

Mr. M. L. Meadors presented the rates proposed by the Ocean Forest Hotel for rooms and meals at the annual session in May. These rates were approved.

Adjournment.

Signed (Secretary)

MEETING OF COUNCIL, FEBRUARY 14, 1949 COLUMBIA, S. C.

Present: Drs. Mayer, Smith, Sease, Baker, Stokes, Chapman, McCants, Macdonald, Durham, Thackston, Price and Mr. M. L. Meadors. Also present on invitation were: Drs. Bozard, Barron, Browning and Hoshall.

Dr. J. H. Stokes, Vice Chairman of the Committee on Medical Service, recommended the following as non-medical members of the board proposed Surgical and Obstetrical Service Plan: Mr. W. W. Loran, Sumter; Dr. George Wilds, Hartsville; Mr. Earl Britton, Columbia; Miss Annette Duchein, Spartanburg; Mr. J. M. Blalock, Columbia; Mr. Jesse T. Anderson, Columbia; Mr. M. L. Meadors, Florence. The secretary was instructed to write to these individuals requesting that they serve on the tentative Board of Directors. The Secretary was also instructed to write to Dr. J. D. Guess, Chairman of the Committee on Medical Service, who was unable to attend the meeting, telling him of the action taken.

The special committee on Naturopaths presented

its report which consisted of a recommendation for the passage of a Basic Science Law for South Carolina. The committee was instructed to confer with the State Board of Medical Examiners relative to this proposed action and to submit a joint report to the Secretary who in turn would submit it to Council by mail for approval.

A letter was presented from Dr. G. C. Engel, President of the Medical Society of the State of Pennsylvania, in which he presented a Ten Point Program for Federal aid to improve medical care. Council approved this program and the Secretary was instructed to so write Dr. Engel.

The meeting adjourned.

Signed (J. P. Price, Secretary)

The following members of the Association have paid the A. M. A. assessment of \$25.00 as of February 20.

Abbeville	Blacksburg	Warren, J. H.
Boggs, M. J., Jr.	Campbell, T. A.	Wilson, Robert, Jr.
Mabry, F. L.	Bowman	Chester
Poliakoff, A. E.	Black, A. L.	Gaston, John N., Jr.
Power, E. L.	Calhoun Falls	Henry, Wm. J.
Rosenberg, George	Tate, John V.	Marion, M. L.
Stanfield, Thos. F.	Ward, A. C.	Patterson, V. P.
Anderson	Camden	Smith, C. Conrad
Bailes, Charles	Brailsford, A. M.	Clemson
Bolt, W. C.	Brunson, J. W.	Milford, Lee W.
Bradham, A. C.	Humphries, A. W.	Clio
Camp, E. W., Jr.	Rhame, George S.	Graham, Chas. M.
Chambers, Geo. W.	West, C. A.	Clover
Clinkscales, G. S.	Whitaker, A. B.	McGill, Waldo K.
Dixon, Jas. H., Jr.	Chapin	Parker, Carl. P., Jr.
Elgin, C. E.	Hamilton, R. G.	Columbia
Gaines, Thos. R.	Charleston	Adcock, D. F.
Haddock, S. H.	Ball, Frederick M.	Asbill, D. S.
Jordan, Henry S.	Best, L. K.	Black, Herbert M.
Martin, John W.	Bowers, T. E.	Bryan, Leon S.
McWhorter, W. B.	Cain, F. G.	Bunch, Geo. H.
Prevost, C. T.	Carter, Patricia A.	Burnside, A. F.
Pruitt, H. A.	Deas, Henry	Cantey, Wm. C.
Pruitt, Olga V.	Harrelson, M. C., Jr.	Claytor, Hubert, Jr.
Ross, S. H.	Herbert, Kenneth H.	Epting, Charles H.
Smethers, A. L.	Hoshall, Frank A.	Ferguson, R. B.
Swain, Bruce	Frierson, John H.	Hart, W. A.
Warder, Frank M.	Lynch, Kenneth M.	Heyward, N. B.
Wilds, Edwin L.	Maguire, D. L.	Holler, John E.
Wyman, J. W.	Martin, T. Hutson	Hutchinson, M. E.
Young, Charles H.	Moore, Matthew S.	Josey, A. I.
Young, Jas. P.	Moseley, Vince	Kinder, E. C.
Andrews	McInnes, B. Kater	Lindler, C. K.
Whitley, W. E.	Parker, Edward F.	Madden, Ethel Mae
Beaufort	Paulling, Robert M.	Madden, L. E.
Black, W. A.	Pringle, Duncan M.	Masters, E. W.
Morse, S. F., Jr.	Prioleau, Wm. H.	Mayer, O. B.
Neidich, Sol	Ravenel, Jas. J.	Mead, Hervey
Belton	Rawl, Alfred E., Jr.	Miller, Ben. N., Jr.
Martin, T. Willis	Rhame, Joseph S.	Miller, Harold
Bennetttsville	Rhett, Wythe M.	Milling, C. G.
Barnes, L. P.	Riley, Kathleen	Moore, A. T.
Callison, Caroline H.	Rivers, Arthur L.	Moore, Henry W.
Charles, Randolph C.	Sanders, Paul W., Jr.	McCutchen, Geo. T.
Evans, Wm., Jr.	Siegling, John A.	Sanders, R. L.
Jennings, Douglas, Jr.	Smith, B. S.	Spivey, C. G.
Kinney, P. M.	Smith, Josiah E.	Tanner, W. O.
May, Charles, R., Jr.	Snyder, Howard	Weston, Wm., Jr.
May, John	Speissegger, Wm. H. S.	Weston, Wm., Sr.
Owens, J. K.	Thomas, John P., Jr.	Westrope, G. R.
Smith, Thos. H.	Van de Erve, John	Workman, J. B., Jr.
Strauss, D. D.	Waring, J. I.	Zemp, F. E.

- Due West
 Pressly, W. L.
 Florence
 Bobbett, G. H.
 Dawson, G. R.
 Hart, W. M.
 Lide, L. D., Jr.
 Price, J. P.
 Stith, R. B.
 Fountain Inn
 Collins, S. L.
 Gaffney
 Brumbach, W. K.
 Cathcart, J. H.
 Hall, Jas. C.
 Nesbitt, Lee T.
 Sanders, Jas. H.
 Sherard, S. B.
 Edwards, G. P.
 Hammett, Jay
 Georgetown
 Tiller, H. C.
 Greenville
 Bates, C. O.
 Bates, P. T.
 Boggs, Lonita
 Boggs, L. W.
 Brockman, W. T.
 Cashwell, R. L.
 Cline, L. M., Jr.
 Converse, J. I.
 Crooks, J. H.
 Crosland, J. E.
 Dacus, R. M., Jr.
 Daniels, F. M.
 Edwards, W. W.
 Fewell, J. M.
 Fisher, Peggy M.
 Fisher, S. H.
 Furman, T. C.
 Goldsmith, T. G.
 Goodlett, W. W.
 Grimball, I. H.
 Guess, J. D.
 Harper, Dewitt L.
 Haynsworth, C. H.
 Hill, John B.
 Holmes, Gertrude R.
 Holtzclaw, J. N.
 Houston, R. E.
 Jervcy, J. W.
 Jordan, Fletcher
 Judy, W. S.
 Lipscomb, J. E., Jr.
 Mathis, Wm. H., Jr.
 McCalla, L. H.
 McLawhorn, B. C.
 McLean, J. W.
 Nachman, M.
 Parker, Jack D.
 Parker, Thos.
 Poole, E. B.
 Powe, W. H., Sr.
 Powe, W. H., Jr.
 Robinson, John F.
 Ross, Henry F.
 Schulze, Wm.
 Simmons, John F.
 Simmons, W. W.
 Smith, Hugh P.
 Smith, Keitt H.
 Stanley, R. R.
 Taylor, L. H.
 Watson, W. H.
 White, C. C., Jr.
 White, J. Warren
 Wilkinson, Geo. R.
 Williams, E. H.
 Wyatt, C. N.
 Yeargin, C. E.
 Greer
 Allen, D. L.
 Flynn, Jas. T., Jr.
 Peoples, M. L., Jr.
 Woodruff, F. B.
 Hemingway
 Ulmer, J. G.
 Honea Path
 Stoudenmire, D. C.
 Kershaw
 Wideman, J. W.
 Kingstree
 Ravenel, L. J.
 Sanders, Keith F.
 Lake City
 Whitehead, J. D.
 Lancaster
 Barber, E. B.
 Crawford, R. L.
 Harris, J. C.
 Pittman, J. D.
 Renner, R. G.
 Latta
 Carpenter, F. L.
 Laurens
 Edgerton, N. B.
 Little Mountain
 Sease, J. C.
 Marion
 Cantey, S. O., Jr.
 Dibble, E. M.
 Finger, Elliott
 Michie, D. E.
 McColl
 Buckner, Margaret
 Moore, Geo. C.
 Moore, J. C.
 Nesmith, L. E.
 Mullins
 Cañ, J. P., Jr.
 Johnson, F. N.
 Martin, Frank L.
 Martin, Jas. L.
 Martin, W. Dan
 McMillan, C. B.
 Myrtle Beach
 Joseph, G. P.
 Newberry
 McCullough, J. H.
 Nichols
 Gilmore, H. S.
 North Charleston
 Herring, H. D.
 Kane, John J.
 Orangeburg
 Albergotti, J. M., Jr.
 Boatwright, P. J.
 Brabham, V. W., Jr.
 Culler, O. Z.
 Marcus, H.
 Price, N. C.
 Shecut, J. C., Jr.
 Thackston, L. P.
 Truluck, Geol M.
 Whetsell, W. O.
 Willis, A. E.
 Wolfe, A. B.
 Yost, O. E.
 Piedmont
 Campbell, S. O.
 Rock Hill
 Brown, A. G.
 Dunlap, J. O.
 Macdonald, Roderick
 Murrah, T. A.
 Strait, W. F.
 Simpsonville
 Milford, M. T.
 St. Matthews
 O'Cain, R. K.
 Symmes, T. H.
 State Park
 Moncrief, Wm. H.
 Summerville
 Messervy, T. W.
 Taylors
 Brunson, J. E.
 Travelers Rest
 Gaston, S. B.
 Walterboro
 Ackerman, Riddick, Sr.
 Ackerman, Riddick, Jr.
 Bennett, Wm. M.
 Brown, G. D., Jr.
 Chapman, C. G.
 Chapman, J. W.
 McDaniel, Wm. P.
 Vonlehe, J. A.
 Winnsboro
 Floyd, J. B.
 McCants, C. S.
 York
 Strong, E. E., Jr.
 Out Of State
 Hearin, Willard C., New Orleans
 Smith, Hugh, Jr., Boston, Mass.
 Anderson County
 Mustard, H. S.
 Young, A. A.

HISTORICAL SIDELIGHTS

A HISTORY OF THE SOCIETY FOR THE RELIEF OF THE FAMILIES OF DECEASED AND DISABLED INDIGENT MEMBERS OF THE MEDICAL PROFESSION OF THE STATE OF SOUTH CAROLINA A. J. BUIST, JR. Charleston, S. C.

(Editor's Note—It is with pleasure that we publish this account of one of the most unique medical societies in existence today.)

On the 19th day of December 1848, upon proper petition of a group of doctors from Charleston, S. C., the General Assembly of this State passed an Act incorporating The Society For The Relief Of The Families Of Deceased And Disabled Indigent Members Of The Medical Profession Of The State Of South Carolina. The principal end of this corporation as set forth in the Act was to "Succor and maintain, and relieve the families of deceased and disabled members of the medical profession of the State of South Carolina."

We are here tonight not only to dine together as is required by the Constitution of our Society but also to commemorate the 100th Anniversary of the founding of this organization. Accordingly, it seems only proper at this time to recall to our memory the interesting and pertinent facts associated with the founding of our Society and to trace its history through its many years during which, despite various vicissitudes and adversities, it has constantly been ready to render assistance to those of our profession or their dependents whom fate has placed in a position of need.

Your Society is a unique one; unique in that to the best of my knowledge it is one of only three such organizations in the Medical world. I wish that I could tell you more of its sister Societies, but what I know of them is very meager and is known to most of you. We are antedated by an organization in London, England. Dr. Hillyer Rudisill informs me that several years ago while in London he had the pleasure of meeting one of the officers of this Society and that his impression is that it is a much larger and wealthier group than ours, being managed and conducted somewhat along the lines of group insurance. The third is located in the State of New Jersey. I do not know its name nor its location, but the late Dr. Robert Wilson was my informant to the effect that its purposes are similar to ours and that we are of greater antiquity.

I wish that in this historical sketch I could with accuracy inform you as to the circumstances of our Society's organization and give to you beyond all

question of doubt the name of one man or group of men in whose mind or minds the concept of forming a charity such as ours was born. Unfortunately, I cannot with certainty do this for reasons which I will shortly mention, but I am prepared to offer to you the name of an individual who I believe may well be the originator of our Society and to offer you certain proofs from the minutes of the Society in support of this statement. The name I have to offer to you is that of Dr. James P. Jervey. You will doubtless recall the historical fact that during the siege of Charleston in the course of the Civil War—or as I was instructed to call it at the last annual banquet the War for Southern Independence—that numerous articles of worth and many historical documents of value were transferred to the interior of the State for their preservation and safekeeping. The minutes of this Society reveal that the then Secretary, Dr. H. W. deSaussure reported at the annual meeting on February 4, '63 that he was unable to read the minutes of the previous meeting because of the fact that he had had transported to Camden, S. C., for safekeeping, the minute books, Charter, Constitution and all records in his possession. These records were to quote the minutes of the next annual meeting held on January 8, '68, "destroyed in flames by Sherman's Army in the course of his infamous march through the State." It is fortunate that the books and records of the Treasurer were for some strange reason kept in his custody and were therefore not lost. These books came into my hands when I was elected Treasurer by you and it is from these records alone that I can piece together the history of our Society until the year 1867. From them I can with certainty state that Dr. James P. Jervey was one of the founders of our Society. I submit his name as its originator based on several other findings. First, in the attempt to regain his health during the latter years of his life, Dr. Jervey was forced to leave Charleston in 1870 and at that time submitted his resignation to the Society. The minutes of the annual meeting at which this was done state "that the society accept with deep regret the resignation of Dr. Jervey who was one of the most active founders of the Society and its originator" and at this time he was made a life-long honorary member of the Standing Committee, an honor which has been shown to no other member before or since. Again, immediately following his

death in 1874, a special called meeting of the Society was held for the purpose of drawing up a fitting preamble and resolution concerning his death, an honor again not accorded any other member. However, I must state that this resolution does not repeat the notation of 1870 to the effect that he was *the* original.

Passing from the conception of this Society to its reality, the records of the Treasurer reveal that dues were first paid in the year 1850 and that the annual assessment was \$12.00. Twenty-five members constituted the original enrollment on the Treasurer's books, but of these twenty-five men, only seven saw fit to pay their first year's assessment making the total collections for the year \$84.00. The president was Dr. James Moultrie, the Vice-President Dr. E. Geddings, the Secretary Dr. H. W. deSaussure, and the Treasurer Dr. D. J. Cain. The Standing Committee was composed of Dr. T. G. Prioleau, H. R. Frost, T. Y. Simons, J. Bellinger, E. Horlbeck, E. H. Deas, T. L. Ogier and W. T. Wragg. The Stewards were Drs. P. C. Gaillard and J. S. Mitchell. The annual meeting of the Society was by Constitution held on the Saturday preceding the third Monday in April. Two years later this was changed to the Tuesday preceding the third Monday in February, and in 1868 it was again changed to our present date, the second Wednesday in January. Nowhere can I find any explanation as to why these changes were made. The first annual banquet was apparently held in February, 1853, for I note that shortly thereafter the Treasurer's books show a debit of \$68.25 with the notation that this represents payment on account of wines and liquors \$18.25 and on account of annual supper \$50.00. From that date until the present, except for the four years of its disbandment from 1864-1868, the Society has never failed annually to dine together as ordered by the Constitution.

The Society prospered during its first decade and up until the Civil War. Its first occasion to render assistance to a dependent was in the year 1858 when the sum of \$100.00 was voted to Alfred, son of Dr. J. Y. Simons. In 1859 a second beneficiary was added, this being the son of Dr. Gaillard, and the amount donated being \$100.00. These annual grants were continued until 1863 when the minutes reveal that Dr. Simons' son had left with the Army and hence was no longer in need of financial help and that Dr. Gaillard's son be continued in his education with the annual appropriation of \$100.00.

A meeting of the Society was held in February, 1863, of which the minutes are available. There is no intimation in the minutes of either the Standing Committee or the Society that the latter would not meet again until 1868 and we are forced to our own conclusions as to why the Society was inactive during the last year of the War and the first three of the Reconstruction period. It is of interest to describe the Society as of February 4, 1863. It had an enrollment

of 38 members actively paying dues and had in recent years lost several others who resigned to serve in the Confederate Army. Its total income had amounted to \$8,425.24, its grants to those in need had amounted to \$800.00 and its invested securities were valued at \$6,657.21. These investments are listed as follows:

Blue Ridge R. R. Bond	\$ 500.00
112 Shrs. Bank Stock	2,622.88
6% Stock of City of Chas.	99.00
Confederate Gov. & Defense	
Bonds of S. C. 8%	1,400.00
Confederate Gov. Script	600.00
Dr. Pritchard's note	158.60
Dr. Deas' note	60.00
Dr. Barker's note	60.00
Total	\$6,657.21

It will be noted that the notes of three members are listed with the securities in spite of the fact that the Constitution then and now specifically states that no monies of the Society can be loaned to any member thereof. Needless to say, these notes together with the remainder of the invested securities were never collected because of the impoverishment following the War.

On October 11, 1867, a special meeting of the Standing Committee was called by the President, Dr. James Moultrie. Present were Drs. Moultrie, deSaussure, Horlbeck, Wragg, Chazzal, J. P. Jervey and the Treasurer, John L. Dawson, who had succeeded to this office in 1854. The purpose of the meeting was in the words of Dr. Moultrie, "to ascertain the state of funds of the Society; what property was left after the devastation of the War, and to take some steps to resuscitate the Society and to revive the interest of our Profession in it, the impoverished condition of our community produced by the War indicating the necessity and importance of keeping in existence and activity a Society whose sole aim and object is to afford assistance to the families of the members of our profession whom death may remove or disability incapacitate from the labor necessary for the support of their loved ones."

The Secretary then stated that all of his records had been lost, in the manner indicated by me earlier. The Treasurer reported that the securities reported at the last meeting were worthless with the exception of City Stock of \$110.00 and a Blue Ridge R. R. Bond of \$500.00 guaranteed by the State, neither of which were paying interest at that time. The President then appointed Drs. J. P. Jervey and Elias Horlbeck to act as a committee to bring in recommendations concerning the reactivation of the Society and six weeks later it reported its suggestions:

1. That the Society be reactivated and called for its annual meeting on the 2nd Wednesday in January, 1868.
2. That the dues be halved from \$12.00 to \$6.00, but payable in advance.

BRONCHIAL ASTHMA

"Aminophyllin has in recent years taken a definite place in the armamentarium of asthmatic medication. Physiologically it acts by relaxing the bronchial muscles. It is also extremely valuable in relieving patients of an adrenalin fastness and is less contraindicated in cases with cardiac disorders or hypertension."¹

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*Searle Aminophyllin contains at least 80% of anhydrous theophylline. G. D. Searle & Co., Chicago 80, Illinois.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Mountain, G. E.: Bronchial Asthma, J. Iowa M. Soc. 35:324 (Aug.) 1945.

3. That all monies owed the Society by members in the form of notes of arrears be forgiven.

These resolutions were adopted by the Standing Committee and the first post-War meeting of the Society was held at Tullys on January 8, 1868. Seventeen members attended from a total membership of 26 and 9 new members were inducted. It was found that two copies of the Constitution were still in existence and it was ordered that first, the Secretary should have others printed, and that second, he should open new minute books with proper notations as to the origin and previous condition of the Society. The recommendations of the Standing Committee as mentioned above were adopted. Unfortunately, the Secretary in opening new minute books did not carry out the instructions given him concerning the origin and previous condition of the Society, and was not able to have copies of the Constitution printed because of lack of funds in the Treasury.

Following its reorganization the Society suffered still further financial hardships. In 1875 it had invested in State Bonds over one-half of its accumulated savings. In that year the General Assembly passed a bill calling all State Bonds at 50% of their face value, new bonds to be issued at 50% on the dollar. The reaction of the Treasurer and Standing Committee was very similar to the reaction of a great many sensible and thoughtful persons to some of the actions of the New Deal in the thirties. However, the Society slowly got reestablished on a sound basis; in 1905 there were thirty members and the Assets of the Society were roughly \$9,000.00; in 1924 the membership had increased to 62 and the Assets to \$13,000.00; and at the present time we have 93 members and our Assets are \$20,000.00.

Perhaps the Constitutional Amendment which has had the most to do with the bettering of the Society's financial condition was passed in 1893; namely, that the Society annually permanently reinvest 25% of its total annual income from all sources. The records reveal, however, that this rule was not always observed in subsequent years up until 1908. However, from that date until the present time it has been strictly observed, with the result that during the preceding Treasurers' tenure of office of 35 years, the funds of the Society doubled, in spite of the fact that two bank failures cost it over \$1,100.00.

The first occasion for the Society's aid after its reorganization occurred in 1879. Since then there has been no year in which someone was not aided by this organization. At times the beneficiaries have been as few as one in number, but at others as many as six have received annual assistance in varying amounts. It may be of interest to you to know just what your organization has done in terms of dollars and cents. Twenty-three beneficiaries have received to date \$20,341.00. The most that any one beneficiary received was \$3,125.00, and one family received \$4,250.00.

The average donation to any one person needing assistance is roughly \$885.00. No history of this Society would be adequate without mentioning what to us may seem humorous, but to him was no doubt very serious, namely the donation of \$75.00 made by the Society in 1907 to Dr. T. S. Grinke for the purpose of buying a false nose to mask the defect caused by a cancer of that organ having eroded away his God-given one.

Reference was made above to the fact that in 1868 the Treasury did not have available sufficient funds to provide for the reprinting of the Constitution. It was not until 1880 that reprinting of the Constitution was made, and this because of the fact that only one copy of the original printing was then known to be in existence. When your present Treasurer took office and in doing so took possession of the Society's bank box, in it he found a tattered and very much shop-worn copy of the edition of 1851 which he presumes to be the only extant original copy and the one referred to in the minutes of 1880 as being still in existence. It is here tonight for your inspection if you care to examine it, after which I would like to turn it over to the Secretary for safekeeping along with other records in my possession. I also have here tonight some of the Securities owned by the Society in 1863 which were also in the bank box. Unfortunately, they are of value only as museum pieces and in demonstrating that the Society then, as now, was a firm believer in the integrity and value of its Government's obligations.

It is most interesting to note that at the time of its formation an applicant for membership in this Society had to be both a member of the Medical Society of S. C. and the Medical Association of the State of S. C. This was subsequently amended to read that Physicians of good standing could apply for membership if recommended by two members of the Society, but by being a member of the above two organizations an individual could make application at any time without endorsement. This somewhat confusing paragraph was later wisely deleted completely.

The only other Constitutional change of any note was made in 1924. Prior to that time Rules II and III of Section V stated among other things, that a potential beneficiary of the Society should ask for assistance and should submit certain information for the consideration of the Society; namely, "the number, age and sex of the applicant and the condition of their bank, funded, or other stock, or their estate both real and personal, and the income of each applicant, however derived." These requirements were wisely abolished and in their place the present Rule II of Section V was substituted whereby funds are distributed at the discretion of the Standing Committee upon approval of the Society.

Concerning the officers of your Society, they have not been many in number and their terms of office have been long. Your Society has had in its one

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From where I sit
by Joe Marsh

Yes, Sir, Insomnia's Contagious!

Bud Swanson had trouble sleeping nights last summer. Tried to get over it by turning up the radio full blast and started an epidemic of insomnia all down the block!

Folks finally dropped a hint to Bud that he close the windows or turn the radio a little lower. Bud did—and that was the quickest cure for *other* folks' insomnia I've ever heard of!

Not that any of us object to the radio, or swing bands, or anything else that helps another person relax of an evening. (Myself, I like a glass of beer with a bit of cheese before I go to bed. I can't speak for you.)

From where I sit, good neighborliness means nothing more than simply respecting the other person's tastes and rights—without forcing your own tastes or opinions down his throat. And that goes for Bud's radio, my glass of beer, or whatever temperate pleasure *you* happen to enjoy.

Joe Marsh

hundred years only 11 Presidents. Their names are as follows: Drs. James Moultrie, E. Ceddings, Elias Horlbeck, T. L. Ogier, W. H. Hunger, R. L. Brodie, T. Grange Simons, C. W. Kollock, E. F. Parker, J. C. Mitchell and R. S. Cathcart. It has had five Secretaries: Drs. H. W. deSaussure, his son, H. W. deSaussure, C. M. Reese, Lane Mullally and G. McF. Mood. Seven Treasurers have served you: Drs. D. J. Cain, P. C. Gaillard, John L. Dawson, I. L. Ancrum, J. S. Buist, A. J. Buist and A. J. Buist, Jr.

I have not been able to find where the name we commonly call our Society, namely the Widow's and Orphans Society, originated. That its official designation, which I will not repeat here, has always been unwieldy is shown by the fact that early in its history the Treasurer's accounts were headed "The Medical Benevolent Society." In the resolutions and preambles presented in the succeeding years are as many distortions and corruptions of the official name as one hears today from the present members. The first time I was able to find the words "Widow's and Orphans's Society" in print was in 1883 at which time Dr. Ancrum assumed the Treasureship. His accounts and those of his successors bear that heading. This name also crops up from time to time in the minutes of the Standing Committee, but at later dates than the one

mentioned above.

Our Society, as you well know, is not confined in its membership to members of the Medical profession, for Rule II of the Constitution specifically states that any person of good moral character may be a member. While it is true that only the families of members of the Medical profession can become beneficiaries, nevertheless in the past we have had at least four members from outside our own profession, one of whom is a member at this time.

As I stated at the start of this history, this Society is unique. I close with the same thought, for to my knowledge and belief it is one of the few organizations an individual can join with the fervent hope that not one cent of any money contributed by him will ever have to be made available to any of those near and dear to him, and that his sole benefit from his membership will be derived from the comradeship of the annual banquet. If these thoughts continue in the years to come to dominate the minds of those joining this organization, by the time of the next centennial anniversary the funds of this Society will have accumulated to the extent that its beneficiaries can expect considerable relief from the hardships attending poverty.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

A. M. A. LAUNCHES PROGRAM

Mr. Clem Whitaker, heading the American Medical Association's current National Education Campaign in connection with the Administration's drive for compulsory sickness insurance, addressed a conference of State Medical Society representatives in Chicago on Saturday, February 12th.

Among his statements, indicating his accurate appraisal of the situation, and the care with which plans are being made to meet it, were the following:

"*Seriously*, American medicine is engaged in a bitter war for survival as a free institution.

"The welfare of our country, as well as the welfare of the medical profession, is directly at issue.

"This may well be the most momentous struggle of free men against government domination which will be fought out before the American people in our generation.

"The responsibility is tremendous; the work involved for many of us will be nerve-racking . . . and in many cases, it may even seem thankless. But

let's lift our sights to the horizon. This, without doubt, is the greatest opportunity any of us ever will have to play a vital role in determining the destiny of American medicine—and even more important, the destiny of the American people.

"This is it! This is D-Day for all the things we believe in!

"We all know the history of what's happened elsewhere. When medicine goes down, it's the beginning of the end.

"To freedom of speech, freedom of religion, freedom of assembly, and a free press, the world needs to add a new fifth freedom—*freedom of medicine!*

"We have been given warm, whole hearted support by the coordinating Committee of A. M. A. in every phase of the campaign program which we have proposed and undertaken. There hasn't been a dissenting vote. There hasn't been any holding back. There hasn't been any question, at any time, that the American Medical Association wanted a militant program, an affirmative program—and a program which we believe deserves the support of every member of the



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medical profession, and every lay employee who represents it.

"Naturally, the A. M. A., having accepted leadership in this fight, is going to be a target, from this point on, for all the bureaucrats, the socializers and the malcontents. But let's put a stop to carping criticism in our own ranks. We can defeat our enemies, but it's difficult to fight our friends.

"Let's divert the energies of the expert needlers and the masters of invective into the proper channels. It will save a great deal of time here in the A. M. A. offices and in our headquarters, and will enable us to get the campaign in high gear much more quickly.

"I am reminded of those first awful weeks after the disaster at Pearl Harbor when the Japs taunted—"Where is the United States Navy?"—and when thousands of Americans, alarmed at the lack of action, echoed the cry and exclaimed: "Where's our Navy? Why isn't it fighting?"

"When those cries were making headlines, the United States Navy, even though crippled and battered, was putting its ships in order and carefully mapping the battle strategy which finally enabled it to sink the Jap fleet in action. The Jap Navy, which made almost every naval error in the books, might have been better off if it, too, had spent some time in intelligent planning and organizing.

"The A. M. A.'s Navy and Army, let me assure you, are not inactive. And when the showdown battle comes in Congress, I have an idea that all of us will be glad, and proud, that we built on a sound foundation."

OPPOSITION TO EWING PLAN INCREASES

Within the past few weeks there have been increasing signs of growing opposition to the Ewing-Truman plan for compulsory sickness insurance. What may at first blush, have appeared to many as the long-awaited answer to the problem of physical ills, is being better understood as the facts are more widely disseminated and the full implications of the scheme are being realized.

Not simply more individuals are seeing the issue in a different light. More than one important nationwide organization composed predominantly of non-medical persons, have recently expressed in formal statements, their opposition to the proposed measure.

Of outstanding importance among these have been the American Legion and the American Farm Bureau Federation.

On January 27, 1949, the Board of Directors of the Farm Bureau Federation announced its opposition. Earlier the Board had sent a telegram to the Senate Labor Committee, asking that action on the current Bill (S.5) be deferred until interested parties were given an opportunity to present their views. The text

of the statement issued by the Board is as follows:

"Tremendous progress has already been made in meeting our health problems through voluntary health associations, which provide medical and hospital services to members on a prepaid basis. We give all-out support to extension of such services on a voluntary basis, but we strongly oppose plans under which the Federal Government would embark on programs providing similar services on a compulsory basis. We have consistently opposed compulsory health insurance, not because we fail to appreciate the seriousness of the problem, but because we believe the desired result can be achieved more completely, more satisfactorily, and more democratically by other means.

"We favor adequate health services, accessible at all times to citizens through voluntary programs providing hospital and medical care, facilities to train more doctors and nurses, establishment of local health units, and broad programs of health education.

"We believe that voluntary programs result in better medical service in greater volume than will be provided in any compulsory program, and at the same time will do much to develop individual self-reliance and independence."

A. M. A. CONSIDERS RURAL HEALTH

The fourth annual meeting of the National Conference on Rural Health was held at the Palmer House in Chicago on February 4th and 5th.

Bringing together leaders in the principal national agricultural organizations, and others concerned with the health of the rural population, the Conference affords an opportunity for free and frank discussion of the problems involved in this field. No specific action toward accomplishing their solution is attempted by the Conference, but full inquiry into the subject and freedom of expression is encouraged.

The American Medical Association, in arranging the Conference, offers the type of leadership expected of it by lay organizations and individuals. Their idea of the value and importance of the meeting is attested by the number and type of the individuals attending.

The National Committee on Rural Health, Dr. F. S. Crockett, Chairman, showed foresight and imagination in the arrangement of the program this year.

The afternoon of the first day was devoted to panel discussions, under capable leadership and some of these developed keen interest. Subjects discussed were: "Health Education—Individual and Community Responsibility," "Environmental Hazards," "Nutrition and the Soil," "The General Practitioner in Rural Practice," and "Cooperative Health Programs for Rural Areas."

Discussion of the last mentioned subject was en-

livened under the leadership of Dr. Dean Clarke of Boston, and Mr. Jerry Voorhees, a former Congressman. The former's motion to have the Conference officially sanction the principle of Cooperative Hospitals and call upon the A. M. A. for its approval, was defeated by a margin of only two votes.

Highlight of the entire meeting was the luncheon address on the second day of the Conference, by Dr. John O. Christianson, head of the American Farm Bureau Federation. A most able and attractive speaker, he entertained his audience delightfully, while he drove through, in no uncertain terms, his views on the necessity for independence and self-reliance on the part of the individual citizen. Dr. Christianson left no doubt in the minds of his hearers where the leadership of his organization stands on the issue of government administered compulsory sickness insurance.

The day preceding the Conference on Rural Health was the occasion for a Conference of members of State Rural Health Committees, a large number of whom were in attendance. South Carolinians included among the latter, and present for this and the Conferences on the days immediately following, were Dr. Harold S. Gilmore of Nichols, Chairman of the Rural Health Committee of the South Carolina Medical Association; Dr. A. W. Browning of Elloree, a member of the same Committee, who represented the State Board of Health; and Dr. W. L. Pressly of Due West, the American Medical Association's General Practitioner of the Year.

MEDICAL PROGRAM OF THE U. M. W. A.

Anyone who listened to the calm, factual statement by Dr. Warren F. Draper in Chicago, must have been deeply impressed with the sincerity of his purpose and the promise it holds for all of us.

Dr. Draper, who spoke before the National Conference on Medical Service, February 6th, is Executive Medical Director of the Welfare and Retirement Fund of the United Mine Workers of America.

A former Deputy Surgeon General of the United States Public Health Service and Major-General in charge of the Public Health Branch at Supreme Headquarters Allied Expeditionary Forces during World War II, his ability as a Public Health Executive can scarcely be questioned. A member of the A. M. A. House of Delegates for twenty years, his position in his profession would seem to be fairly well established.

He presented a perfectly fair, completely reasonable plan which he and the leaders of the Miners' Union propose to follow in administering the fund. As outlined, it contains nothing to which the most ardent proponent of "free enterprise" or the most hypercritical observer of "organized labor" could object.

It holds within itself proof of the ability of Americans, organized and aligned by trades and professions for protection and improvement, to reason together and work out their mutual salvation—on *one condition*—that each group shed its smugness, its determination to have its own way—all the way—drop the chip from its collective shoulder—and try sincerely to actually *do* something concrete for that wonderful American system of free enterprise which we all profess to love so dearly.

More power to Dr. Draper. May he receive the cooperation from Union leaders and medical profession alike, which will make possible the realization of his objectives without resorting to other methods.

RURAL HEALTH

(As viewed by the American Farm Bureau Federation)

The quality of American medical service is very high. Unfortunately, American medical service at its best reaches only a relatively small part of the rural areas of the country. The shortage of physicians, hospitals and other medical facilities in the rural areas is not due to less need for medical care than in cities. The primary factors which most influence adequate medical facilities and which attract physicians are community environment and economic opportunity.

There is a wide gap between existing medical knowledge and the health practices in many rural areas. Rural people must first know their existing facilities and whether or not they are adequate. They must know the meaning of high standards in hospital and medical care. They must be taught the advantages of budgeting the costs of medical need as they do other household expenses. They must know the significance of health hazards around the farm home as they pertain to disease, including the relationship between animal diseases and human health. They must know what services offered by public and voluntary agencies are available to them, and they must discover their own health needs and formulate their own program.

For this reason we heartily commend the health programs already under way in some of our State Farm Bureaus, and urge other states to follow as soon as practicable. We also recognize promise in the long-range health education program carried on by the Agricultural Extension Service. We urge the Land-Grant colleges to expand this program to the extent that they have an extension health education specialist on their staffs.

We suggest that our State Farm Bureaus give serious consideration to the desirability and possibility of offering scholarships whereby physicians, surgeons, dentists, and nurses will be encouraged to establish themselves in rural areas. We believe the problem of

improved health can best be met by the voluntary organizations of cooperative health associations which will encourage people to take advantage of the services available for any medical or dental care which they may require.

We stand ready to cooperate with the rural health committee of the American Medical Association and other groups in providing better voluntary medical care for rural people. We urge the continued interest and cooperation of the states in cancer, tuberculosis, venereal disease, polio, crippled children, heart and rheumatic fever programs. We also endorse the American Red Cross National Blood program and recommend active participation by our Farm Bureau members. We favor voluntary plans providing medical, health, dental, and hospital insurance. We urge that facilities of medical schools be expanded, and every effort be made otherwise to train more physicians, surgeons, dentists, nurses, technicians, and general practitioners and public health doctors. We recommend the full cooperation of rural people with our established health units and existing health programs, including immunization, clinics, nutrition courses, and home nursing. We believe greater emphasis should be given to preventive medicine. We suggest that in states where permissive legislation for the creation of public health units does not exist, State Farm Bureaus secure enactment of such legislation.

We favor reasonable appropriations for grants-in-aid to states for maternal and child health programs, and also to assist states in the expansion of needed public services and facilities. To the extent Federal grants are needed by way of assistance, such grants should be made to states on the basis of need, with state governments responsible for the allocation and administration of these funds.

The American Farm Bureau Federation has consistently supported the Hill-Burton Hospital Construction Act, and we will support the continuation of this Act and appropriations necessary to achieve the objectives of the law. The American Farm Bureau Federation urges the state Farm Bureaus to cooperate in the administration of the act in their respective states. In the administration of the Act, agriculture must have adequate representation on national and state advisory councils.

COMMITTEE WORKS ON FEE SCHEDULE

The Committee appointed by Council in January to draw a tentative fee schedule for approval of Council and subsequently by the House of Delegates, met in Columbia on Monday afternoon, February 14th, to begin its deliberations. All members were present but one. The Committee, of which Dr. J. Decherd Guess of Greenville, is Chairman, and Dr. J. Howard Stokes of Florence, Vice-Chairman, includes two general practitioners and representatives of all the specialties which will be concerned with the services under the

proposed Surgical and Obstetrical Care Plan.

At the meeting on February 14th, the Committee made preliminary study of fee schedules in use by the Hospital Savings Corporation of Chapel Hill, N. C., and other groups. The North Carolina Corporation offers service similar to that being planned for this state, and the Committee was of the opinion that, in the main, the fees allowed in North Carolina would probably be about in line with those which should be allowed here.

A number of other schedules are to be studied and additional information obtained. The Committee will then hold further meetings to deliberate at length before reaching any conclusion on the schedule to be recommended for the South Carolina Plan. The first meeting was marked by general agreement on the principles that should be followed in fixing the schedule. The Committee realizes the necessity for both satisfying the physicians that they are being adequately paid for their services, and also of adopting a schedule sufficiently reasonable to permit the Plan to operate safely on the basis of rates that are both actuarially sound and low enough to be within the reach of the subscribers in the lower income brackets, for whom the Plan is primarily intended.

Complying with the request of Council, the Committee, at the same meeting, took under consideration, and after general discussion, decided upon seven non-medical persons in the state, whose names were recommended to Council for recommendation by the latter body to the House of Delegates for election, at the annual meeting, to the Board of Directors. At a meeting immediately following that of the Committee, Council accepted the recommendations, and these laymen will be recommended along with the eight doctor members, to compose a fifteen-member Board of Directors. The final choice will be up to the House of Delegates, which, under the By-Laws of the proposed Plan, will elect the Board at the time the organization is completed.

Additional information on the principles of the proposed Plan will be issued from time to time in the near future. Every member of the Association is urged to give attention to these releases and make himself familiar with the proposals and with the purpose which the Plan is intended to accomplish.

PHYSICIANS URGED TO VOLUNTEER FOR ARMED SERVICES

Dr. Sensenich, A. M. A. President, recently referred to the Association's support of a nationwide drive by the Armed Services Advisory Committee to recruit volunteers. The younger physicians who received all, or part of their education at Government expense, or those who were deferred for service because of their status as medical students, are being urged to volunteer for service in the Armed Services



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Dept. for Women

at this time, wherever reasonably possible for them to arrange to do so.

The purpose of the drive to find recruits is to relieve the critical shortage of physicians in all branches of the Service. The Committee stressed the fact that physicians who volunteer will be utilized, as far as possible, in an assignment suited to their professional skill and ability.

COMMITTEE FAVORS DEPARTMENT OF WELFARE

After hearings held on the few days immediately preceding, the House Committee on Expenditures in the Executive Departments, at an evening meeting on February 15th, acted favorably upon H. R. 782, a Bill providing for a separate Department of Welfare, the head of which would be a Secretary with Cabinet status. The American Medical Association had given approval to the suggestion of creation of a Department of Health.

The Bill, as reported out by the Committee, carried two minor amendments, neither of which apparently would affect materially the organization, general authority, nor scope of operation of the proposed new Department.

BLUE CROSS PROGRAM SHOWS PROGRESS

The recent, second annual report of the South Carolina Hospital Service Plan shows a record of steady, if slow progress during the year just completed.

The net enrollment at the end of 1948 was 22,777 contracts, covering 59,572 persons. This represents an increase during the year of 10,857 contracts and 29,674 persons. Of all members 22,777—or 38 percent—are employed subscribers, and 36,795—or 62 percent—are dependents. About 900 groups were enrolled during the year, bringing the total number of groups to approximately 1,500.

During 1948 the Plan paid an overall total of 5,644 hospital bills, representing 33,473 days of care. In 1947, 1,355 hospital bills were paid, providing 8,084 days of care. (It should be pointed out, however, that the comparison between the two years is not accurate, in that, in 1947 the Plan operated for only nine months.)

Financially, the Plan is operating on a sound basis, and conservatively. Its earned income during 1948 was \$325,994.51. Payments to hospitals amounted to 70.7 percent of earned income. Operating expense for the entire year was 21 percent of earned income. Indicating, however, the usual trend toward reduction of the proportional operating expense, it should be noted that the percentage dropped from 24 percent of earned income in January to 17.9 percent in December. This is directly in line with the experience of practically all plans, which are able to reduce their operating expense with experience and increased efficiency which comes from practice.

Five more hospitals signed contracts in 1948, bringing the total number of member hospitals to 33. There remain about ten hospitals of importance in the state which have not become members, and it is evident that, in order to procure these, higher Plan payments to the hospitals will be necessary.

A Committee was appointed at the recent annual meeting to study further the average costs and average billings of the member hospitals, with the view to determining to what extent the hospital payments should be increased. It is believed that a raise in subscription payments will be necessary to effect this increase to hospitals, and that such an increase to subscribers would be justified and will be readily accepted by the membership in general.

The physicians are urged to continue to give increasingly, their support and encouragement to the efforts of the Blue Cross Plan. Volunteer hospital service and medical service, whether on commercial or non-profit basis, are essentials in the current struggle with the advocates of the Government scheme.

DEATHS

JOHN D. SMYSER

Dr. John D. Smyser, 61, superintendent and surgeon in charge of the Saunders Memorial Hospital in Florence, died of a heart attack on February 15.

A native of New Jersey, Dr. Smyser received his M. D. from the University of Maryland and did post-graduate work at Johns Hopkins. In 1912 he located in Florence, devoting his time to ophthalmology and otolaryngology. During World War I he served with great credit as an officer in the medical corps. Upon his return from World War I he reopened his office in Florence and in 1921 founded the Saunders Memorial Hospital of which he became superintendent and later surgeon in chief. At the time of his death he was owner of the hospital, having purchased it three years ago.

In 1919 Dr. Smyser was general chairman for South Carolina at the organizational caucus of the American Legion at St. Louis. From that time on he was very active in the work of the Legion and served as one of the early commanders of the Post in Florence. He was a charter member of the Florence Kiwanis Club and Chairman of the City Board of Health at the time of his death.

Dr. Smyser is survived by his widow, the former Miss Janie Susan Saunders.

ELIAS DOAR TUPPER

Dr. Elias Doar Tupper died at his home in Summerville on January 20.

A native of Summerville, Dr. Tupper received his education at Porter Military Academy and at the Medical College of the State of S. C. (Class of 1905). Following his graduation he located in Summerville where he engaged in general practice along with some surgery. At the time of his death he was chief of staff of Dorchester County Hospital.

Dr. Tupper is survived by his wife, four sons and two daughters.

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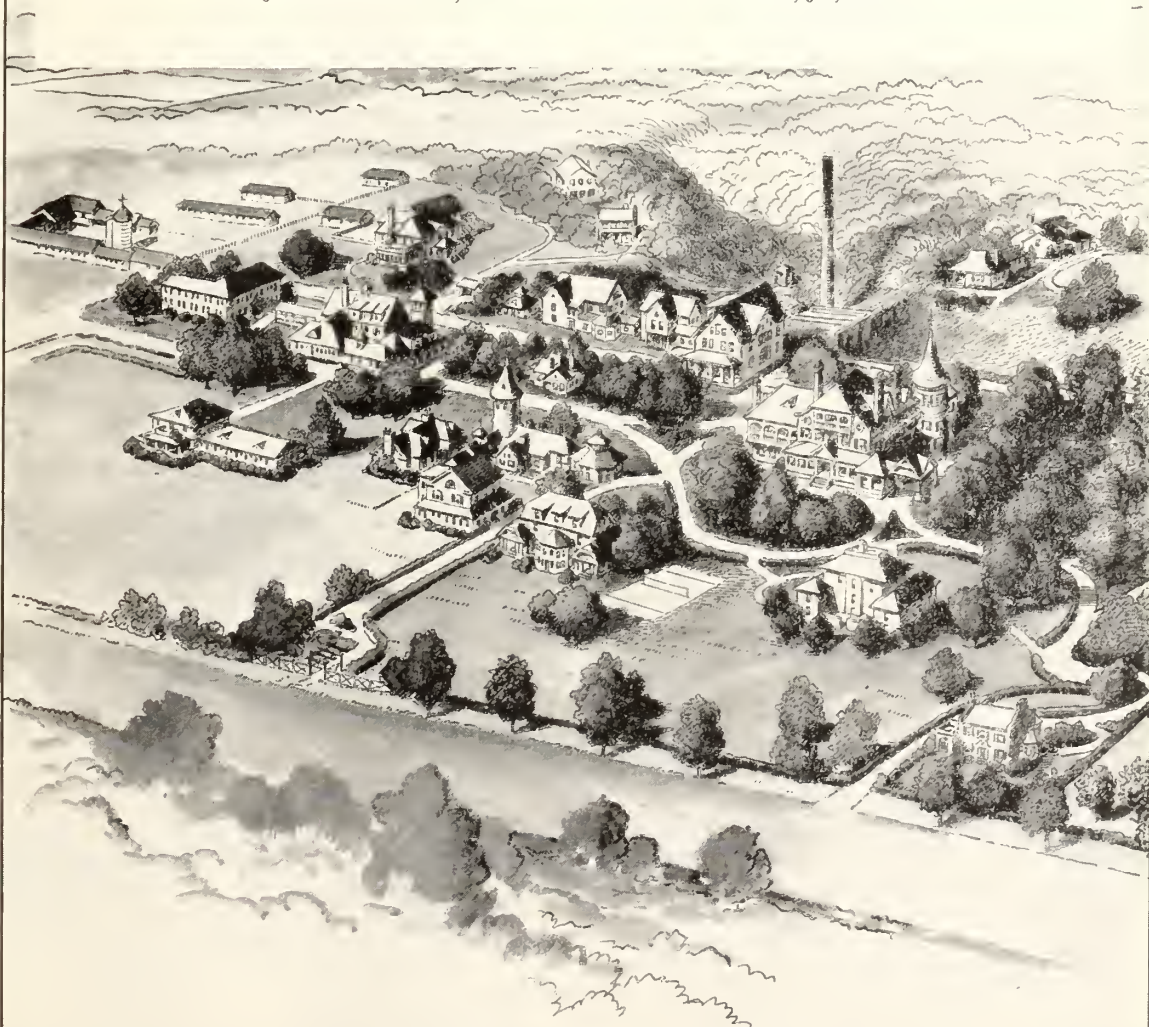
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L I T E R A T U R E O N R E Q U E S T

NEWS ITEMS

Dr. William R. DeLoache is opening offices in Greenville for the practice of pediatrics. Dr. DeLoache is a graduate of Furman University and Vanderbilt Medical School. He interned at Vanderbilt University Hospital prior to serving two years in the Army. Upon returning to civilian life he did residence work in pediatrics at Bowman-Gray Hospital, Winston-Salem, N. C.

Dr. L. E. Mays and Dr. H. H. Wells have announced the opening of The Medical Clinic at Seneca, for the practice of general medicine and surgery.

Dr. G. B. Hodge has successfully completed Part II of the American Board of Surgery examinations given in Baltimore in December, and is now a certified Diplomat of the American Board of Surgery.

Dr. J. Gordon Seastrunk of Columbia was elected president of the South Carolina Trudeau Society at a meeting held recently in Columbia. Dr. S. E. Miller of Georgetown is secretary of this group.

The South Carolina Mental and Social Hygiene Society (Dr. Hilla Sheriff, President) held a meeting in Columbia on February 10. Among those speaking were Dr. Ben F. Wyman, Rev. James W. Jackson, D. D., of Columbia, and Dr. A. C. Flora, Superintendent of Columbia City Schools.

Dr. and Mrs. Jack Scutty of Greenwood are receiving congratulations upon the birth of a daughter, Elizabeth Jane, on January 20.

The South Carolina Pediatric Society met with representative orthopedists in Columbia on February 9, to discuss the general polio situation in the state and to map out plans for better care for acute and chronic cases in children.

Dr. Charles N. Wyatt, President, presided at the semi-annual meeting of the Tri-State Medical Association, February 21 and 22.

Dr. S. J. Shippey of Rock Hill was recently elected President of the York County Medical Society for 1949. Serving with him will be Dr. W. K. McGill of Clover, Vice President, and Dr. Carl Parker of Clover, Secretary-Treasurer.

Dr. J. W. McMeans of Florence, was married to Mrs. Erma Williams Dunbar of Conway, on January 20.

Dr. and Mrs. David Watson of Greenville have announced the birth of a son on January 5.

UROLOGICAL POST GRADUATE SEMINAR

The American Urological Association through its Southeastern Section announces a Urological Post Graduate Seminar to be held in New Orleans, Louisiana, April 18, 19, 20, and 21, 1949. The Seminar will be under the auspices of the Division of Graduate Medicine, Tulane University School of Medicine. William D. Frye, M. D., Dean of the Graduate School of Medicine will be the director of these courses in collaboration with the officers and Executive Committee of the Southeastern Section and with the representative of the Central Committee.

The course is designed especially for young urologists, urological residents, surgical interns

especially interested in urology, and physicians and surgeons who do diagnostic urology (part time). It will be of especial value to those preparing for the American Board of Urology, but will afford an excellent review for all urologists.

The courses will be limited to 150 registrants. The cost will be \$50.00 except for urologic residents. Because of the great amount of interest already expressed by members in our Section, an early application is recommended.

Address inquiries and applications to:

Wm. W. Frye, M. D., Dean
Graduate School of Medicine
Tulane University
New Orleans, Louisiana

Dr. William T. Barron of Columbia, is South Carolina's representative on the Executive Committee of the Post Graduate Seminar of the Southeastern Section of the American Urological Association and will be glad to receive communications concerning the course.

The Horry County Medical Society held a re-organizational meeting in Conway on January 14, 1949. Attendance was 100%. The newly elected officers for 1949 are: Dr. J. D. Thomas, Sr., Loris, S. C., president; Dr. Cary Durant, Myrtle Beach, S. C., Dr. J. D. Gilland, Conway, S. C., and Dr. W. K. Rogers, Loris, S. C., vice-presidents; and Dr. R. C. Smith, Conway, S. C., secretary-treasurer.

Quarterly meetings will be held. At three of these meetings the scientific program will be given by members of the society. The fourth meeting each year will be held at Myrtle Beach with visiting speakers of distinction.

The next quarterly meeting of the Society will be held March 18, 1949, either at Conway or Loris.

MEETING OF ALLERGISTS

More than 1000 physicians interested in allergy from North America and abroad are expected at the Palmer House from 2 P. M. *Thursday, April 14, to 5:30 P. M. Sunday, April 17.* Everyone who comes is urged to bring his wife and any office personnel interested in the various phases of allergy. Both members and non-members are urged to attend and are required to register and receive a badge. There will be no charge for registration. There will be over 20 scientific exhibits and 40 technical exhibits of interest to allergists.

All those attending the annual meeting are requested to *make their own hotel reservations directly with the Palmer House.* A block of rooms has been reserved for those attending the meeting. Please direct all correspondence to the *Reservation Manager, Palmer House, Chicago 90, Illinois* and include your arrival and departure time, and the type and rate of room desired. Be sure to indicate that you are attending the meeting of the American College of Allergists.

DOCTOR WANTED FOR ARKANSAS COUNTY

The Methodist Church is looking for a physician to settle and serve in Newton County, rural northwestern Arkansas, where 10,000 are without a doctor or nurse, and the nearest hospital is twenty-five miles from Jasper, the county seat.



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In the ranks of the mop and pail brigade many of the recruits are on the far side of forty. To those whose work is made doubly difficult by menopausal symptoms, "Premarin" may bring gratifying relief. The prompt remission of physical symptoms and the sense of well-being usually experienced following the use of "Premarin" can do much to restore normal efficiency . . . Other advantages of this naturally-occurring, conjugated estrogen are oral activity, comparative freedom from side-effects and flexibility of dosage... "Premarin" is available in tablets of four different potencies and in liquid form.

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Five years ago the Methodist Church organized the "Newton County Larger Parish," built a stone church in Jasper, and now has two experienced pastors carrying on a program of evangelism, religious education, and community service. The ministers cooperate with the agricultural agent and others in economic betterment, have a farmer's cooperative, etc.

If a doctor can be found for the community, the Methodist Church will organize community support for the erection of a clinic, with a laboratory and a

few beds, and will subsidize the establishment until the practice is built-up. The doctor will reside in Jasper, will be related to public health and school health, and the state will probably supply a nurse.

For further information, write to Dr. M. O. Williams, Board of Missions and Church Extension, 150 Fifth Avenue, New York 11, N. Y. This is one of a large number of calls Dr. Williams has for physicians and nurses in the United States or abroad—some of them as missionaries, some, as above, as private practitioners.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. P. M. Temples

Publicity Secretary: Mrs. William H. Folk

NEWBERRY GROUP HEARS MRS. TEMPLES

Mrs. Powell M. Temples, president of the Woman's Auxiliary to the South Carolina Medical Association spoke of organizational plans and outlined a program of work for the auxiliary, stressing health education, at the organizational meeting of the Newberry County Medical Society on Tuesday afternoon.

The meeting was held at the home of Mrs. Augustus T. Neely. Mrs. Edward G. Able is president of the Newberry Auxiliary.

The speaker was accompanied by Mrs. W. H. Folk, state publicity chairman.

Mrs. Powell M. Temples, President, Woman's Auxiliary to the South Carolina Medical Association, was presented a lovely camellia corsage when she was the guest speaker at the February Meeting of the Woman's Auxiliary to the Edisto County Medical Society in Orangeburg.

Mrs. J. M. Albergotti, President of the Edisto Auxiliary acted as toastmistress at the luncheon meeting. There were approximately thirty members present.

Mrs. Temples spoke to the group about various phases of auxiliary work, stressing the importance of contacts with the lay people by auxiliary members and Mrs. Temples gave some interesting facts about Diphtheria Immunization.

Mrs. William H. Folk, State Publicity Secretary, accompanied Mrs. Temples to Orangeburg. Mrs. Folk made a few remarks and asked continued cooperation from members in sending articles for publication. Mrs. Folk was presented a beautiful corsage.

After the luncheon a tour of the flower gardens, including the famous Edisto Gardens, was enjoyed.

Mrs. Temples and Mrs. Folk were house guests of Dr. and Mrs. Vance W. Brabham, Sr.

THE VALUE OF A MEDICAL AUXILIARY

By Mrs. Manly E. Hutchinson

The twentieth century, rich in the general stirring of many movements, will go down in history as an era of bloody wars, an era of political, economic, and social unrest, an era of scientific and industrial progress, and an era in which womanhood began to attain her true place under the sun. Politically, socially, economically and intellectually, women are prepared to face the world side by side with members of the masculine sex.

We women of the deep South, caught in the swift current of progress, are willing and delighted to cherish the traditions of chivalry and courtesy from our

men, which we have been taught to regard as our heritage. In this tide of progress, let us ever cling to the gentle touch, the grace and charm of manner by which we are known, using these silken cords as lead reins for the realization of our ambitions.

For we women of the deep South are part of the general movement in our country to organize and band together for the purpose of learning, of teaching, of helping, and even of crusading when we believe there is a cause to be won. Look at our national, state, and community organizations, the church groups, the garden clubs, the P. T. A's, the study groups, the leagues for this and that, the auxiliaries to every known association.

"When you want something done, get a group of women interested in it." How often have you heard that remark? And probably more often from men than from the women, themselves.

Yes, indeed, we have attained a place under the sun—a place which we have won by our skill and labors. Our capabilities have been definitely recognized. Yet with this recognition comes an even greater degree of responsibility and a challenge to our intelligence. There comes the question of evaluating our time, of deciding where and how to work for the greatest common good.

No intelligent person can question the fact that woman's primary place is still in the home. Here lie the interests that are closest to her heart and to her happiness.

Church work is and should be of paramount importance to us. Many of us parents feel that we should like to give our free time to the P. T. A. A garden lover will want to be an active worker in her garden club. There are so many and such diversified ways in which we can stay busy that it is hard to decide where to spend our talents and our time to the best advantage. However, it seems to me, and it has evidently seemed so to many thoughtful women, that when we decided to become MRS. DOCTOR, we decided not only which would be the most important profession in our lives but which organization would, at the same time, become most important to us.

Next to the duties, responsibilities and obligation to her home and to her church, the chief duty, responsibility and obligation of the doctor's wife is to her Medical Auxiliary. Just as the Medical Society is the most important organization to which a doctor belongs, the Medical Auxiliary is, and should be, the most important organization to which a doctor's wife belongs.

Aside from the question of duty, responsibility and obligation, aside from the actual work accomplished by the Medical Auxiliary, our organization is, and

should be, of utmost importance to us because of what it represents—of what it stands for. The most valuable single feature of the Medical Auxiliary is that it is the liaison, the go-between the medical profession and the public with its first objective—I quote from Article II, Section 1 of our state constitution—"Through its members to extend the aims of the medical profession to all organizations which look to the advancement of health and education."

Let us think of ourselves primarily as a liaison organization. We are not an independent organization and we do not seek to act independently. Webster defines the word AUXILIARY to mean "conferring aid, or help—an assistant, and that is the relationship we must bear in mind to our medical association. We do not seek to work for our own glory, but anything that we can do to add to the prestige, dignity and honor of the medical association is that which we must do. The scope of our potentiality is so vast that sometimes we lose sight of the fact that we are not working for ourselves alone. We certainly do work for honor to our group, but to the end that greater glory and honor shall fall upon the medical profession. It is the self-less aspect of our work that gives it its greatest dignity.

Let us pause and review the objectives of our auxiliary from three aspects:

1. Our responsibility to ourselves.
2. Our responsibility to our medical association.
3. Our responsibility to the community.

It is only through the complete understanding of these three responsibilities that we can hope to feel that we are of value as a medical auxiliary.

We are a part of a vast national organization numbering more than 50,000 members. South Carolina has a membership of 545 members, but we are still far from having a complete representation of the wives of the doctors in our state. We are far indeed from the realization of our goal: "Every eligible doctor's wife a member of the medical auxiliary." Is every eligible doctor's wife in your district a member of your auxiliary? More than likely she is not.

So your first responsibility is to look to your membership and to make it as complete as you possibly can. Not only that, but encourage attendance at meetings. Make it your personal responsibility as an active member, yourself, to bring with you someone who is only lukewarm in her interest. Make the social part of your meetings so attractive that everyone will want to be there. Also, see that you pay your dues promptly, and remind others to do so. Remember that no organization can function without a good treasury, and remember that you are not recognized as an active member in the state organization unless your dues are paid by the middle of March.

Thus, working for a full membership, you are fulfilling your second responsibility to yourself and Article II, Section 3 of your constitution, which reads: "The objects of this auxiliary shall be (3) to promote acquaintanceship among physicians' families that fellowship may increase." Let your meetings always be governed by harmonious feelings of friendship and fellowship. Strive to make the new members feel welcome and at ease at your meetings.

Your third responsibility to your auxiliary and to yourselves is to BE INFORMED. Self-education is essential in our work, for before we can educate others we must educate ourselves. Our work revolves around the family and the community, and anything that we can do to further and cement the aims of medicine, particularly the comprehensive health program of our parent body, is our duty. So, how can we talk about

the Ten Point Program of the A. M. A. unless we know what it is? How can we discuss Blue Cross or Blue Shield unless we know what they are trying to do? It is our duty to know, so find out and be in a position to discuss these programs intelligently.

Not only should we know about the aims of medicine, but we should also know as much as possible about the threats to organized medicine, the so-called socialized medicine program advocated by certain leaders in our country. This subject should be studied not only from the point of view of the average citizen who will be prone to see only the advantages offered, but also from the point of view of those who foresee the vicious evils resulting from such a system. There was an excellent article in the October issue of our state Auxiliary Bulletin on "State Medicine in New Zealand." An understanding of this article alone will give us strong arguments against any form of state medicine in our country.

How can we keep ourselves informed on subjects of importance to the medical profession? By a study of the S. C. Medical Journal, by a study of the S. C. Auxiliary Bulletin, which is published by the S. C. Medical Association primarily to keep us informed about medical legislation, and finally by a study of our national auxiliary Bulletin. These three sources alone will give us much information. There are many others. Your legislative chairman will receive timely information on pending legislation, and it is her duty to keep you informed. Call on speakers from your local and state medical societies, or public health authorities or members of the nurse's association. The more we can learn about many things, the greater value we shall be to medicine and the more nearly we shall arrive at realizing our greatest responsibility to ourselves.

Let us consider next our responsibility to our medical society. Theoretically, when we have fulfilled our responsibilities to ourselves and to the community, we have fulfilled our responsibility to our medical society. It is important for us to remember always that we are not free to act independently in anything. Whatever we do must have the consent of the medical society, or at least of the Advisory Council appointed by them to guide us. Work with your Advisory Council freely. The closer we can crystallize our relationship to the parent body, the stronger we shall be.

Practically, there are many ways in which we can be of service to our doctors and help gain for them the prestige and recognition they deserve. Anticipate their needs and their wants. There are some excellent suggestions in the October Auxiliary Bulletin. Have you read them?

The Auxiliary can be of great service to the local medical society by collecting and compiling the biographies of locally deceased physicians. You have a special committee chairman for that purpose. Co-operate with her to get as much biographical material as you can each year. You are required to file this material in the state archives in Charleston, but keep duplicate copies of these biographies in permanent files within your own auxiliary. I believe this idea is a new one, but you will find it of great value, and a convenience to you and your doctors should the need arise for its use and arise it will, for papers are frequently written on early local medical practitioners.

I must confess to a dream some day to see our State Auxiliary publish a book on the Biographies of South Carolina Doctors. Such a book is not in existence today. This dream could become a reality were each of the county units to make themselves completely responsible for accurate and detailed biographies of every doctor who had ever practiced in their county. What a tremendous task, but what an achievement that would be for us.

Finally, we come to a consideration of the responsibility of the medical auxiliary to the community. Herein lies the greatest value of the auxiliary to itself and to the medical profession. Looking beyond the fact that we were organized in the past primarily for social reasons, and still admitting the importance of this reason for our existence, we must face the fact that we are organized today for broader and more important reasons. Living as we do in a day of change and progress, we should not be satisfied with the purely social features of our organization. We meet the challenge on very side of service, not alone by our little philanthropic and benevolent activities, but by doing everything within our power to bring about a better and closer understanding between our doctors and the public. Public relations is a broad field and we have only begun to scratch the surface. Anything that you can do to make your auxiliary and your medical society appear in a good light before the public eye is good public relations. Be active in other organizations. Organize and work on health committees for the purpose of giving accurate health information. Sponsor talks by medical experts on tuberculosis, cancer, nutrition, routine physical check-ups and so forth. Two years ago the Columbia Auxiliary was responsible for a newspaper article on routine physical check-ups for women, which appeared on Mother's Day.

Participate in health drives such as the March of Dimes, Red Cross, Christmas Seal sales, Cancer, Community Chest and the like. Do this as an organization whenever you are asked; otherwise urge your members to work independently.

"Do good, be good and tell others." This maxim may be applied in relation to your publicity in the press. Be alert to every opportunity you may have to present your good works to the public. The more credit you get for being an active, wideawake organization the more prestige you will have. Publish good, long articles about your meetings. Get as many names as possible into the article, and whenever you have an opportunity to publish pictures of auxiliary individuals or groups at work, do so. All of this makes for good public relations.

Incidentally, the Columbia Auxiliary has found it advantageous to keep a permanent scrapbook of newspaper clippings filed in chronological order for reference and for historical purposes.

Another good public relations project is to sell "Hygeia." It is published by the American Medical Association, and is the only magazine on the market giving authentic information on health. It is not a profit-making magazine and the editors are largely dependent upon us for its circulation.

Student Nurse Recruitment is another public relations feature. We cannot fail to respond to the request made to us by the president of the South Carolina Medical Association, Dr. R. B. Durham, when he asked us to undertake again this year Student Nurse Recruitment as one of our major objectives. More nurses and better nursing care will help not only our doctors but the people of every community.

Your work in public relations is unlimited. I have touched on only a few of the high spots. With your initiative and zeal you will find countless other opportunities to render service that you will find interesting and gratifying.

In its final analysis, the true value of a medical auxiliary is determined by the individual member. It

is the attitude of the individual member that will, in the end, measure the degree of success or failure of the organization. With enthusiastic and determined spirits working together in close harmony, we can live up to the responsibilities already challenging us and set new goals for even greater service.

CORRESPONDENCE

February 9, 1949

Dr. Julian Price
Editor
The Journal of The South
Carolina Medical Association
Florence, S. C.

Dear Julian:

In addition to the information I sent you last month about the Alumni Post Graduate Seminar I should like to add the following information. The faculty committee has secured the services of the following speakers for the Seminar this fall. Dr. Mayo H. Soley, Dean, Iowa State University, College of Medicine; Dr. Richard H. Lyons, Professor of Medicine, Syracuse University, College of Medicine and Dr. J. Englebert Dunphy, Assistant Professor of Surgery, Harvard Medical School.

Very truly yours,

John A. Boone, M. D.

AN INVITATION

The South Carolina Obstetrical and Gynecological Society will hold its annual meeting at the Columbia Hotel in Columbia on Monday, April 11. The evening session will be a joint meeting with the Columbia Medical Society. The scientific program will begin at 11:00 A. M. The distinguished guest speakers will be Dr. Emil Novak, assistant professor of gynecology, Johns Hopkins University and associate professor of obstetrics at the University of Maryland; and Dr. Louis H. Douglass, professor of obstetrics at the University of Maryland. Local speakers will be Dr. David F. Watson of Greenville and Dr. Herbert Blake of Anderson. The several subjects to be discussed are: The modern treatment of toxemia of pregnancy, modern indications and contra-indications for caesarean section, the endocrine treatment of menometrorrhagia, the endocrine treatment of the menopausal syndrome, sterility, and hysterectomy.

A stag luncheon will be given with their compliments by a leading drug house, and a cocktail party will be given by a distributor of infant foods. The dinner will be stag and dutch treat. Early reservations must be made for these gatherings. (Address Dr. Manly E. Hutchinson, 1412 Bull St., Columbia, S. C.)

All members of the South Carolina Medical Association are cordially invited to attend these meetings.

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Editor

Journal of South Carolina Medical Association
 Florence, South Carolina

Dear Sir:

As you know, the American Board of Preventive Medicine and Public Health, Incorporated, was approved by the Advisory Board for Medical Specialties and by the Council on Medical Education and Hospitals of the American Medical Association at their meeting on February 6. The American Board of Preventive Medicine and Public Health, Incorporated, therefore is prepared to accept applications for examination for certification in this specialty.

As indicated in the attached bulletin, the requirements for certification include general qualifications, such as moral and ethical standing in the profession, adequate training in medicine and internship in an approved hospital, and licensure to practice medicine in the United States. Eligibility for examination also requires that the new applicant have special training and experience in preventive medicine and public health of at least six years following internship. This must include special academic training, or its equivalent, and field training or residency meeting the standards set up by the Board.

Applications may also be received for the Founders Group who may be excused from examination. The By-laws authorize a Founders Group made up of practitioners of preventive medicine and public health who have attained unquestioned eminence in the field. The Founders Group presumably will include persons having attained eminence as indicated by academic appointments at the level of professor or associate professor of preventive medicine and public health, or who have held positions of eminence and responsibility for a period of not less than ten years in this field.

Sincerely yours,

Ernest L. Stebbins, M.D.

Secretary-Treasurer

American Board of Preventive Medicine
 and Public Health, Incorporated

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Summary of Combined Benefits Provided in Policy Form UG 20N—477U Rider of United Benefit and PG 20N—745M Rider of Mutual Benefit

Monthly Benefit	Double Monthly Benefits for Specified Travel Accidents	Accidental Death Benefit	Double Accidental Death Benefit for Specified Travel Accidents
\$400.00	\$800.00	\$10,000.00	\$20,000.00

ACCIDENT BENEFITS

	Regular Indemnity	Specified Travel Accident Benefit
Total Disability, per month for LIFE, if incurred before age 60	\$400.00	\$800.00
Total Disability, per month for LIFE, if incurred after age 60	200.00	400.00
Partial Disability, per month, for 3 months	160.00	320.00
Physician's and Surgeon's Fees, for nondisabling injuries	50.00	50.00

SICKNESS BENEFITS

Confining sickness, per month for LIFE, if incurred before age 60	\$400.00	Nonconfining sickness incurred after age 59: Benefits payable up to twelve full months, per month	\$200.00
Confining sickness, per month for LIFE, if incurred after age 60	200.00	Thereafter — even for a LIFE-TIME—per month	100.00
Nonconfining sickness incurred prior to age 59: Benefits payable up to age 60, per month	200.00	ADDITIONAL BENEFITS	
Thereafter — even for a LIFE-TIME—per month	100.00	Hospital Benefits (either sickness or accident), per month, up to 3 months	200.00
		Nurse's Benefits (if hospital confinement not required), either sickness or accident, up to 3 months	200.00

ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFITS

	Regular Indemnity	Specified Travel Accidental Death
Accidental Death	\$10,000.00	\$20,000.00
Loss of Both Hands	10,000.00	20,000.00
Loss of Both Feet	10,000.00	20,000.00
	Regular Indemnity	Specified Travel Accidental Death
Loss of Both Eyes	\$10,000.00	\$20,000.00
Loss of One Hand and One Foot	10,000.00	20,000.00
Loss of Either Hand, Foot or Eye	3,000.00	6,000.00

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- Covers all accidents except aviation and even covers specified air travel accidents.
- Covers all illness except syphilis, venereal disease, insanity or mental infirmity.
- Waiver of Premium Provision.
- No reduction in benefits because of occupational change of duties.
- Nonaggregate—full limit of benefits paid for each disability.
- Double Limb Loss Benefits may be paid in one lump sum or in monthly installments for life provided total disability is incurred.
- Loss of one hand or one arm may be paid in one lump sum or in monthly installments for as long as five years, provided total disability is incurred.
- No Automatic Termination Age.
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- Pays disability benefits resulting from accidental bodily injury (the means or the act causing the injury is not a determining factor in the claim).
- The Companies offer eligible members of your profession policies which guarantee your right to renew except for these reasons only: Nonpayment of premiums; if the insured leaves the practice of the profession; or, if renewals are declined on all like policies issued to members of your profession in your state. This means that the Companies cannot decline to renew any individual policy without similarly declining to renew all like policies issued to members of your profession in your state.



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TEN POINT PROGRAM
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1. Cooperation

To promote closer cooperation and better understanding between all groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Political Control

To prevent political control or domination of medical practice or of medical education.

3. Study

To assemble and to amplify studies relative to the need and availability of medical care in each county of the state and in the state at large, and to publicize these findings.

To study all agencies in the state which are involved in the administration of medical care as to the type of work which they are doing and the effectiveness of the work which is being done.

To promote plans for providing or improving medical care where there is a need.

4. Care of Indigent

To prepare a uniform plan for the hospital care of the indigent, financed by public county funds, which may be used by individual counties or by groups of counties for their indigent sick, and to promote the general adoption of such a plan.

To promote the establishments of clinics in each county for the indigent ambulatory patients, financed by public county funds and operated or supervised by established hospitals or by the county medical society.

5. Hospital Insurance

To make voluntary hospital insurance available to all the people of the state and to promote the widespread purchase of such insurance.

6. Hospitals

To study the present availability and facilities of hospitals in the state and to promote the establishment of well-equipped and adequately-staffed hospitals in needy areas.

To establish through the State Medical Association standards for hospitals in South Carolina and to make public the names of those hospitals which meet these standards.

7. Group Health Insurance

To promote the establishment of group health insurance plans in all industries, large and small, in South Carolina.

8. Standards for Insurance

To establish standards for insurance companies selling hospital or group health insurance in South Carolina and to publish the names of those who meet these standards.

9. Medical and Nursing Education

To promote the securing of adequate funds and facilities for the operation of the Medical College of the State of South Carolina.

To promote advancement in nursing education and nursing care in the state.

To promote the establishment of a loan fund whereby worthy young men and women of the state who are financially unable to meet the strain of a medical education may be able to secure aid.

10. Education of the Public

To acquaint the citizens of the state with regard to the agencies and facilities in the fields of medical care, public health, hospital and industrial insurance, and to encourage the people to use them on a much greater scale.

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Tularemia Acquired From The Bite Of A Wood-Tick

CASE REPORT

by

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Although the great majority of reported cases of tularemia have resulted from contact with infected rabbits, a number of other vectors have occasionally been incriminated. Among those listed by Francis¹ in a series of 1859 cases is the wood tick, which was responsible for 73 instances (3.9%) of the disease. Most of the cases reported in South Carolina have been acquired from rabbits. However, a recent case in which the wood tick was responsible showed a dramatic result of treatment with streptomycin and is of some interest.

CASE HISTORY

W. C. H., a 40-year-old white farmer, was admitted to the Roper Hospital on the evening of July 2, 1948. Three weeks previously he had found a wood tick on the skin of the upper right thigh and thought that he had removed it, head and all. Two days later swelling of the adjacent inguinal lymph glands was noted, and this was followed by irregular fever, chills, and pain in the lumbar spine. An ulcer developed at the site of the initial tick-bite and his physician, who was first consulted at this time, gave him Procaine Penicillin-G, 300,000 units a day for four days. This therapy was without effect, as was a short course of sulfadiazine. The possibility of tularemia was then considered and he was brought to the hospital for treatment. During the few days immediately previous to hospitalization the temperature had risen to 104 degrees at sometime each day.

On admission the temperature was 102 degrees, the pulse rate 100. Complete physical examination was negative except for the presence of slight but definite generalized lymphadenopathy, marked enlargement of the right inguinal lymph glands with considerable tenderness on palpation, and a punched-out, well-circumscribed ulcer on the anterior surface of the



Figure I. Picture shows primary ulcer and swelling of adjacent inguinal lymph gland.

right thigh about 2 inches below the inguinal ligament. The ulcer was about half the size of a dime and showed a necrotic base. There was also a line of several small papules extending medially for a distance of about 2 inches from the inner edge of the ulcer (See cut)

A diagnosis of probable tularemia was made and the patient was begun on streptomycin, ½ gram every 6 hours. A blood culture taken before the drug was begun was reported several days later as negative. The urine was negative. The total white cell count was 17,500 with 70% neutrophils. Blood for agglutination tests taken on admission to the hospital was negative for *Proteus* X-19 and for *P. tularensis*. Three days later the agglutination test repeated for *P. tularensis* was strongly positive in a dilution of 1 to 640 and

weakly positive up to a dilution of 1 to 2560.

Symptomatic response to streptomycin was almost immediate; by the next day the patient was feeling a great deal better and had very little pain in the inguinal region. On his second day in the hospital the temperature was up to 102, on the third day to only 100 degrees and thereafter remained normal. He received $\frac{1}{2}$ gram of streptomycin every 6 hours for 5 days (a total of 10 grams) and for 3 more days received $\frac{1}{4}$ gram every 6 hours. At the end of his eighth day in the hospital the temperature had remained normal, the white cell count had fallen to 8600, the ulcer was rapidly healing, inguinal lymphadenitis was subsiding, and he was discharged to continue convalescence at home.

DISCUSSION

In the past 11 years, 10 cases of tularemia have been reported in Charleston County; of these, 8 patients were treated in the Roper Hospital. In 4 cases in which specific treatment was not given the average hospital stay was 30 days and the average duration of fever was 16 days. In 4 other patients streptomycin was used. The first patient of this group had had a fever of 16 days duration when the diagnosis was made and received a total of 21 grams of streptomycin. The temperature fell from a daily level of 105 degrees to normal within 48 hours. In the second case, with a fever of 9 days duration, 1 gram of streptomycin each day for 6 days was used and response was obtained at the end of 4 days treatment. The 2 other cases were already improving when the diagnosis was established

and although streptomycin was used successfully, their recovery could not be altogether attributed to the drug.

The effectiveness of streptomycin in the treatment of tularemia is well-established.² A recent report by Berson and Harwell³ summarizes the clinical data in 56 cases of Tularemia treated with streptomycin in Veteran's Administration Hospitals. The only death occurring in their series was attributed to carcinoma of the pancreas. The total dosage used in the 56 reported cases varied from 1.9 grams to 20 grams, averaging 8.1 grams, and the duration of treatment averaged 9.1 days.

SUMMARY

(1) A case of tularemia following the bite of a wood-tick is reported; this was of the ulcer-glandular type, with no pulmonary involvement, and successful treatment with streptomycin was used, with a total dosage of 13 grams given in an 8-day period.

(2) Attention is called to the effectiveness of streptomycin in reducing the length of hospitalization and in appreciably shortening the duration of the illness and in lessening the incidence of complications.

REFERENCES

1. Francis, Edward: Textbook of Medicine by R. L. Cecil, 5th edition (1942). W. B. Saunders Co.
2. Foshay, L.: Am. J. Med., 1, 180, 1946.
3. Berson, R. C. and Harwell, A. B.: Am J. Med. Sc., 215, 243, (March) 1948.

The Rh Factor

CHARLES H. KINGSBURY, M. D.^o
Florence, S. C.

To understand the subject of the Rh factor it is necessary to bear in mind two fundamental facts: First: that the human body will produce antibodies in response to the introduction of certain foreign materials and; Second: that human red cells have varying types of antigenic substances attached to them. The first of these substances, discovered in 1900 by Landsteiner, were designated A and B.

Another substance is called Rh, some form of which is present in 87% of the Caucasian race and absent from 13%. Rh is a general name and includes at least three sub groups, but these rarely occur singly and one member, Rho is present in 85% of the 87% Rh positive individuals. Ordinarily it is this subgroup that is meant when we speak of Rh positive or negative. It is not within the scope of such a short paper as this to discuss the interrelation of the various sub-

groups nor the theory of inheritance by means of the eight allelic genes. Those interested are referred to the papers of Dr. Edith Potter of the University of Chicago School of Medicine and Dr. Phillip Levine of the Ortho Research Laboratory of Raritan, New Jersey, and others. It is sufficient for practical purposes to know the Rh positive individuals are divided into homozygous and heterozygous groups. Homozygous males will always have Rh positive offspring and this group constitutes about 42% of all Rh positives.

The other 58% of Rh positive males are heterozygous and about half of their children will be Rh positive. In the male population immunization can be brought about only one way: By the introduction of Rh positive blood into the circulation of Rh negative individuals. In the female it can occur in two ways by incompatible transfusions and by occult transfusions caused by the escape of Rh positive fetal cells from

^o(Read before The Pee Dee Medical Society, Feb. 1949)

the vessels in the villi of the placenta during the ordinary course of a pregnancy or more suddenly by intra uterine manipulation during an abortion.

If Rh positive cells do gain access to the circulation and do stimulate antibody production, the immunization thus produced is permanent. Demonstrable antibodies may disappear from the blood stream but they will still make themselves manifest if even minute amounts of Rh positive blood are again introduced.

When a Rh negative woman, who has been immunized conceives an Rh positive child the antibodies in her blood stream pass through the villi, enter the fetal circulation and combine with the Rh positive cells of the fetus causing part of them to be agglutinated and hemolyzed. An antigen-antibody equilibrium is established, the amount of cell destructions being related to the amount and variety of antibody present.

Two types of antibodies are recognized. One is generally known as the saline agglutinating antibody and the other the hypermimic or blocking antibody. Both act as hemolysins. It is thought that the saline agglutinating antibody appears early in the course of immunization and the blocking antibodies appear after more prolonged immunization. The presence of the latter form of antibody indicates a high degree of immunization and appears to exert a more harmful influence on the fetus than do the saline agglutinating antibodies.

Approximately 15% of all women are negative to the common Rho serum. Of this number about 15% can be expected to have Rh negative husbands where offspring will, of course, be Rh negative. Of the remainder about 29% of the infants will be Rh negative by virtue of marriage to a heterozygous male. Thus about 8.5% of all pregnancies are in Rh negative women bearing Rh positive children. Since first pregnancies almost never result in erythroblastosis unless there has been previous incompatible transfusions, and since something less than $\frac{1}{2}$ of all pregnancies occur in primigravidae women, it would appear that the hazard of erythroblastosis is reduced to approximately 5% of all pregnancies. Nevertheless, Chicago Lying In Hospital reports that in a 5 year period between 1941 and 1946 covering 17,500 deliveries erythroblastosis was the second leading cause of death in the new born period, being exceeded only by malformations.

It is apparent then that much attention must be given to determination of Rh status if we are to attempt to reduce this mortality: First: All patients who are to be transfused must be given Rh compatible blood, not only to prevent immunization of Rh negative individuals but also to conserve Rh negative blood from prospective donors, and not waste our supply on Rh positive recipients. Second, all women present-

ing themselves to the physician for prenatal attention should have an Rh determination. If found to be Rh negative her husband should have the Rh test done and, of course, if he is negative no further tests need be done. If the husband is positive, a careful history should be taken concerning transfusions, including small whole blood intramuscular injections; abortions; previous pregnancies resulting in still births or infant deaths and if any significant fact is developed antibody determination should be performed. Also this antibody determination should be made in all multiparous women. This should be repeated at the end of the seventh month. If no antibodies are found no indication exists for modification of delivery nor for a change in immediate postnatal care of the infant.

If antibodies are found, the infant is almost certain to have some degree of erythroblastosis and the question of early delivery presents itself and preparation should be made for proper care of the infant. It should be stated that while early Caesarian section appears to have a theoretical therapeutic value, results so far have been disappointing. Transfusions immediately on delivery through umbilical veins have proven life saving where a woman has previously delivered a proven erythroblastotic infant.

In event of delivery of infant with a lesser degree of congenital hemolytic disease than fetal hydrops, the treatment depends on the degree of anemia and generally the smaller the amount of blood that is necessary to give the better the final outlook. All evidence at present is in favor of the use of Rh negative blood.

Since there has been so much publicity given to the Rh factor in the lay press, the patient usually becomes quite agitated on learning that she is Rh negative. The physician can assure the patient in the event there is no pertinent transfusion history that the vast majority of Rh negative women can have one, two and even three normal Rh positive children before the process of isomization is sufficiently intense. Further, the chances of survival and complete recovery of the affected infant are much greater now.

Unfortunately it is necessary to tell the woman who has become immunized that she will almost invariably give birth to erythroblastotic infants provided the infant is Rh positive as the passage of time between pregnancies seems to make no difference, nor does even the apparent disappearance of demonstrable antibodies alleviate the prognosis. No method of desensitization has as yet been discovered. As a consequence all women who have given birth to an infant with erythroblastosis, especially if severe enough to cause death, should be advised against further pregnancies unless she is prepared to submit to artificial insemination with Rh negative sperm or remarriage to Rh negative husband.

Platybasia With Increased Intracranial Pressure

By

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Platybasia, commonly referred to as basilar impression, is a rare developmental anomaly of the occipital bone and upper cervical spine. Rokitsky¹ (1844) was the first to describe this deformity. From studies by Boogaard,² Virchow,³ Growitz,⁴ and Homén⁵ a clearer understanding of the effects of this anomaly on the nervous system has been evolved. Schuller,⁶ in 1911, made the first correct clinical diagnosis of this condition. However, up to 1942, only 29 cases of platybasia had been reported.⁷

Basilar impression is due to a developmental anomaly of the occipital bone and upper cervical vertebrae. There is stenosis of the foramen magnum and cephalic bulging of the clivus. The base of the occipital bone is flat and elevated and the foramen magnum is displaced upward.

The cervical segment of the spine appears to be pushed up into the base of the skull and frequently there is a posterior arch defect or occipitalization of the atlas. The odontoid process is high and is posteriorly located. Deformity or fusion of other upper cervical vertebrae are not uncommon. These changes are best noted on a lateral radiograph of the skull and upper cervical spine and on a "fronto-vertex" or "occipital projection" of the base of the skull and foramen magnum. In the lateral projection a line drawn from the posterior lip of the foramen magnum to the hard palate will reveal the tip of the odontoid process above this line.

The symptoms and findings in basilar impression are extremely variable. The skeletal findings are usually a short neck with a posterior tilt of the head and limitation of motion. The ears tend to approach the shoulders.

The neurological examination may reveal evidence of cranial or cervical nerve involvement, spinal cord irritation or paralysis, compression of the cerebellum and medulla, and increased intracranial pressure. Many cases of platybasia have been incorrectly diagnosed as syringomyelia, disseminated sclerosis or progressive spastic plegia, only to have the correct diagnosis established at autopsy.

This deformity is easily overlooked in spite of the fact that radiographs of the skull show changes which are pathognomic of this condition.

Secondary platybasia may occur in any systemic skeletal disease in which there is softening of the bones of the skull, as in Paget's disease, hyperparathyroidism, osteomalacia, rickets, lipoidosis, and dy-

sostosis cleido-cranialis.

In those cases in which symptoms result from the deformity, relief can be obtained only by surgery. This consists of a suboccipital craniectomy, upper cervical laminectomy, and opening the dura in order to effect complete decompression.

CASE REPORT

Patient C. M.: A thirteen-year-old colored male was seen in consultation on April 19, 1948, because of severe headache. The history revealed that four weeks previously the patient developed severe, generalized, throbbing headaches associated with anorexia and polyuria. These symptoms persisted and two weeks later he noted tinnitus, vertigo, and occasional diplopia. He also noted some blurring of vision and dysarthria. One week before consultation he became nauseated at intervals and vomited several times. Two days later numbness of the upper lip developed. He had no chills, fever, convulsions, paralysis, or other neurological disturbances. The remainder of the history was entirely negative and non-contributory.

The examination revealed a temperature of 98.6°; pulse, 80; respiration, 20; blood pressure, 110/88. The patient was a well developed, well nourished, intelligent and cooperative, thirteen-year-old, colored male who carried his head in a slight posterior tilt. He guarded all movement of the neck. The general physical examination was within normal limits with the exception of bilaterally hypertrophied tonsils. The neurological examination revealed the head to be symmetrical and on percussion in the region of the coronal suture line a McEwen's "cracked-pot" sign was elicited. There was no cervical rigidity. The optic fundi revealed three diopters of papilloedema with numerous exudates and marked tortuosity and distention of the veins. There were no retinal hemorrhages. A slight peripheral facial paralysis was present on the right. The left heel-to-shin test was poorly carried out, but there was no ataxia or Rombergism. The reflexes were all bilaterally equal and physiological except for a positive Babinski response on the left. The clinical impression of increased intracranial pressure probably due to a posterior fossa neoplasm was made. The patient was admitted to the Spartanburg General Hospital on the following day.

The blood and urine examinations were normal and the serology test for syphilis was negative. Radiologic examination of the skull revealed abnormally increased cortical markings over the entire skull and slight widening of the sutures. The base of the skull was flattened and moderately thickened. The foramen magnum was rather large, having diameters of approximately 3.8

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x 4½ cms. There was a defect in the arch of the atlas posteriorly. Examination of the lateral radiograph revealed the tip of the odontoid process to be above the line drawn from the posterior lip of the foramen magnum to the hard palate. A diagnosis of platybasia with increased intracranial pressure was made.

On April 22, 1948, bilateral posterior trephines were made. This was followed by a ventricular estimation and ventriculograms. The intraventricular pressure was over 600 mm. of C. S. F. The ventriculograms revealed bilateral symmetrical dilation of the lateral ventricles. On the A P view the third ventricle was dilated and in the midline. On the posterior view a little air was seen in the third ventricle and the first part of the fourth ventricle. This study was followed by a suboccipital craniectomy and laminectomy of the first cervical vertebrae. The midsection of the basal portion of the occipital bone was markedly thickened and there was a rather marked impression in the dura in this region. The arch defect in the atlas was bridged by a firm ligamentous fibrous band which constricted the dura at this point. The band was excised and a small segment of the arch of the atlas removed on either side. The dura was opened and a complete decompression obtained. It was found that the cerebellar tonsils were constricted at the foramen magnum and extended downward to a point just be-

low the arch of the atlas. The dura was then closed loosely with interrupted silk sutures and the craniotomy flap was closed in the usual manner with interrupted silk sutures. The patient made an uneventful recovery and was discharged from the hospital ten days later.

The preoperative and postoperative radiographs and the ventriculograms are illustrated.

The examination made at the time of discharge revealed complete clearing of the right facial paralysis and the Babinski response on the left side was again normal. A postoperative check-up two months later revealed complete subsidence of the papilloedema and the neurological examination was entirely normal.

SUMMARY

Platybasia is an uncommon developmental deformity of the occipital bone and upper portion of the cervical segment of the spine. The neurological symptoms and findings resulting from this condition are extremely variable. Many of the cases have been incorrectly diagnosed as syringomyelia, disseminated sclerosis, or progressive spastic paralysis.

Radiographs of the skull invariably show changes which are pathognomonic of this condition.

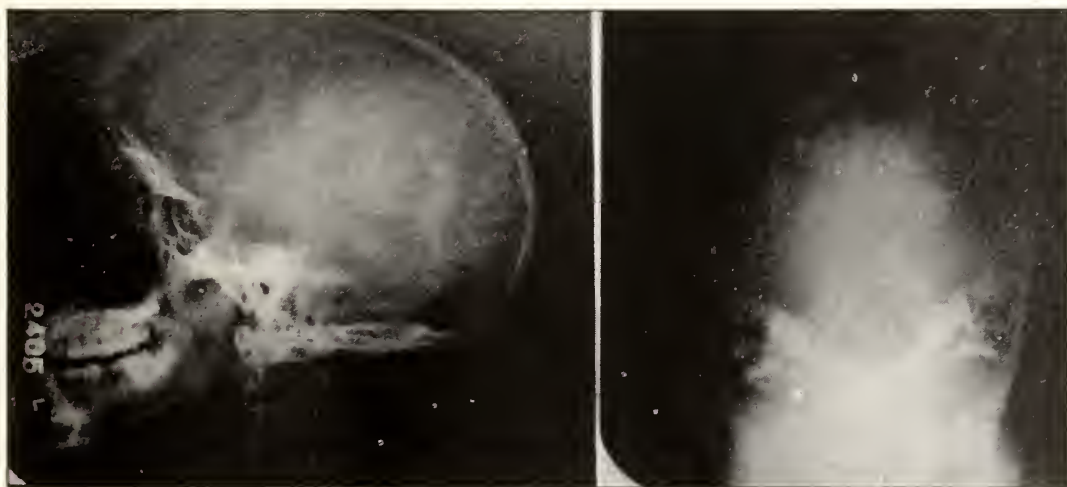


Figure I: Lateral radiograph and "occipital projection" of the skull. On the lateral view, note the flat appearance of the occipital bone. The odontoid process is above a line drawn from the posterior lip of the foramen magnum to the hard palate. This is pathognomonic of platybasia. On the "occipital projection" one can note a large foramen magnum and the posterior arch defect in the atlas.



Figure II: Ventriculograms revealing bilateral, symmetrical dilation of the lateral ventricles. The third ventricle is dilated and in the midline.

A case is reported in which this deformity resulted in increased intracranial pressure and cranial nerve involvement. The patient was successfully treated by surgical decompression.

- (1) Rokitsky: Cited from Ebenius, B., "The Roentgen Appearance In Four Cases of Basilar Impression." *Acta Radiologica*, 1934, 15: 652.
- (2) Boogaard, J. A., "De indrukking der grondolakte van den schedel door de wervelkolom, hare oorzaken en gevolgen." *Ned. Tydschr. Geneesk.*, 1865, 2: 81.
- (3) Virchow, R., "Beitrage zur physischen Anthropologie der Deutschen mit besonderer Berücksichtigung der Friesen." G. Vogt, Berlin, 1876.
- (4) Growitz, P., "Beitrag zur Lehre von der basilaren Impression des Schädels." *Virchows Arch.*, 1880, 80: 449.
- (5) Homen, E. A., "Zur Kenntnis der rachitischen Deformationen der Schadelbasis und der basalen Schadelhyperostosen." *Deutsche Ztschr. F. Nervenk.*, 1901, 20: 3.
- (6) Schuller, A., "Zur Rontgendiagnostik der basilaren Impression des Schädels." *Wien. Med. Wehnschr.*, 1911, 61: 2594.
- (7) Peyton, W. T. and Peterson, H. O., "Congenital Deformities in the Region of the Foramen Magnum: Basilar Impression." *Radiology*, 1942, 38: 131.



Figure III: Postoperative radiographs showing the suboccipital craniectomy.

Psychosomatic Medicine—A Critique

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(Through the help of Dr. Daniel Blain, Medical Director of The American Psychiatric Society, a series of articles dealing with various phases of psychiatry will be published in this Journal. This paper is the first of the series and we hope it will be of real interest to our readers—Editor.)

The medical practitioner of today, eager to improve his diagnostic and therapeutic acumen through periodic literature and other sources, finds in ever-increasing frequency reference made to a supposedly new discipline named psychosomatic medicine which has baffled and fascinated him at the same time. Fascinated because he has long felt the need for a better understanding of emotional factors in disease, hoping thereby to find practical guidance in the handling of his many psychiatric problems encountered in the practice of medicine. Baffled because there is rarely to be found a straightforward discussion of what the concept constitutes, leaving the reader perplexed and confused as to its scope. With this recognition in mind the author has attempted to review the very abundant literature on the subject and to present a condensed account of the works of major contributors in the field. Hinsie and Shatzky¹ refer to "Psychosoma" as being a union of physical and psychic components but do not offer a definition for psychosomatic medicine even though the first edition of their psychiatric dictionary was printed as late as 1940. Leon Soul in Hunt's "Personality and the Behavior Disorders"² states: "Psychosomatic knowledge reflects the maturation of a trend which is evident in many phases of human behavior, a development beyond static, mechanistic, atomic thinking toward a more unified dynamic concept of psychosocio-biological functioning."

A prominent worker in the field, Flanders Dunbar,³ quotes Osler's "The Principles and Practice of Medicine" as an introduction to her text: "Psychosomatic Diagnosis is that part of medicine which is concerned with an appraisal of both the emotional and physical mechanisms involved in the disease processes of the individual patients with particular emphasis on the influence that these two factors exert on each other and on the individual as a whole.

Weiss and English⁶ call psychosomatic medicine the application of psychopathology to general medical problems. They divide psychosomatic problem into three groups:

Group I includes those patients who "are not out of their minds" and have no bodily disease to account for their illness.

In Group II are patients who have symptoms in part

dependent upon emotional factors, in part on organic ones.

Group III includes those patients who have a physical disease largely influenced by emotional factors such as asthma, migraine, hypertension.

A fourth group which also finds mention deals with patients whose bodily disease is the result of structural changes resulting from emotional factors.

Alexander⁷ simply states that psychosomatic research deals with the mind-body problem.

Definitions, constituting attempts to concisely verbalize usually elaborate concepts, are as a rule, easy prey to criticism. However, in order to understand the aims of an investigator in this field it is essential to be acquainted with what he is investigating. A few more may be added here. Felix Deutsch⁸ considers the scope of psychosomatic medicine to be the systematized knowledge of how to study bodily processes which are fused and amalgamated with emotional processes of the past and the present.

Cobb¹⁰ calls psychosomatic by etymology a liaison field between neurology, psychiatry and medicine; it is in his opinion a study of the abnormal functions caused by the emotional stimulation in any system of the body outside the central nervous system and of the resulting lesion.

It is quite apparent from the above definitions that the concept of psychosomatic varies between being very broad to somewhat vague. Alexander,⁷ realizing the desirability of greater uniformity for purposes of research, editorially commented on his views of the fundamental concepts of psychosomatic research, those of psychogenesis, conversion and specificity. Psychogenesis is referred to as consisting of excitation in the central nervous system which can be studied by psychological methods because they are subjectively perceived as emotions, ideas or wishes. Psychosomatic research deals with such processes because they can more readily be studied by psychological than physiological methods.

The second fundamental concept, that of conversion, has suffered most of the abuse according to Alexander. Freud's concept of conversion hysteria was based on the assumption that an unbearable emotion is being converted into a bodily symptom which results in a discharge of the emotion with a varying degree of success. This concept explains quite convincingly the relative absence of subjective anxiety symptoms in hysterical dissociative phenomena. Unfortunately, however, the use of the word conversion is nowadays no longer restricted in its use to dissociative symptoms but is being widely employed to de-

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scribe any somatic manifestation originating in emotional conflict. He stresses the point that no emotional discharge takes place in, for example, such vegetative phenomena as nausea or cardiac arrhythmia since they are but normal accompaniments of the emotion and not substitutive for them in any way.

Alexander divides conversion into two groups: one of the voluntary neuromuscular and sensory perceptive; the other the vegetative group. As examples for the first group he mentions anesthesia of body parts; peptic ulcer belongs to the second and sphincter control to both groups. As regards the third fundamental concept, that of specificity, Alexander expresses the belief that the physiological responses to different tensions are varied and that vegetative dysfunctions result from specific emotional constellations. To that he adds that factors of constitution and organ sensitivity deserve further investigation.

The concept of specificity is the greatest challenge to the intuition and the investigative spirit of psychosomatic researchers who are expending their greatest effort on searching for common denominations in the personality and environment of individuals who show similar psychosomatic reactions.

The chief obstacle in gathering detailed personal information about patients who suffer from disorders such as fractures, coronary disease or hypertension is their frequent unwillingness or inability to provide the doctor with the material he seeks to establish specificity with, if present.

Various techniques were introduced to facilitate interviewing such as associative anamnesis,⁹ which in the main is a compromise between orthodox psychoanalytic procedure of free associations and the direct face-to-face method. The examiner talks but little and encourages the patient to associate by occasionally repeating a few of his own words which may result in the presentation of more material and permit the doctor to get a picture of the patient's attitudes and interpersonal relationships.

Using the above described technique Deutsch believes to have established specificity for some disorders and to have arrived at the general conclusion that diseases such as asthma or mucous colitis are adult manifestations of a childhood conflict which was coincidental with whooping cough and diarrhea respectively, thereby conditioning the child to express subsequent conflicts or the reactivation of the old conflict via the originally affected organ, i.e. lungs or colon. Regarding specificity, he has this to say: Asthmatics have aggressive, domineering mothers who suppress aggressiveness in their child. Their fathers are, as a rule, passive. The asthmatic attacks constitute conscious or unconscious attempts to express a suppressed aggressive tendency against the mother.

In patients with rheumatoid arthritis he found a marked need to express anxiety through motility and

a suppression of this need through the muscle apparatus. In gastric neuroses patients have unconscious wishes which they cannot admit to themselves. Their need for affection is expressed in a desire to be fed which they deny by displaying energy and independence. The stomach, in expectation of food-affection, fills its mucous membranes with blood, stimulates gastric secretion resulting in stomach symptoms of varying severity.

Patients with colitis are guilt-ridden, depressed people who have a desire to give in return for what they receive. They are frequently fastidious and usually show a tendency toward hoarding.

Hypertensives are in need of a dependent relationship which they cannot tolerate. Their attitude is a submissive one; they suppress hostility, fear injury and are emotionally isolated. Hypertension appears when neurotic symptoms fail to drain off hostile impulses.

Referring to diabetes as a true organic disease and not a psychosomatic disorder as such, he goes on to say that diabetics show a tendency toward feelings of deprivation and passivity; their frequent depressive trends are the result of food deprivation related to a loss of love in the prediabetic life period.

The most extensive study of specificity is reported by Flanders Dunbar and her associates.^{3, 4, 5} Of particular significance are their findings on accident proneness and specific constellation in fracture patients. It is of interest that fracture cases were studied with the preconceived idea that these patients were victims of unavoidable misfortune, but showing reasonably normal personality patterns. However, it was soon discovered that accidents do happen but more so to some people than others. A statistical survey of a large number of cases showed that a considerable percentage of patients had more than one accident and in addition a personality pattern which appeared rather typical of the fracture case. Outstanding features are: Low previous illness record, high record of previous accidents, high incidence of childless marriages and small family sizes; there are few obvious neurotic traits; however, these patients are very restless and impulsive at times. In social relations they are "good fellows" and appear casual about their feelings. They make up their minds quickly, are not interested in intellectual values and the accidents occur when aggressive hostility is aroused.

Hypertensive patients have a high previous illness record, high marriage rate, large families and their accident rate is low. Their personality is introversive, perfectionistic, explosive in their expressions; they are ambitious, tense, shy, are ambivalent and experience no discharge of their tensions which accumulate. As a result of a morbid fear of failure they search for alibis and frequently are relieved to learn that they have hypertension.

Coronary occlusion shows a particularly clear-cut

personality constellation. Illness rate is high and so is marriage incidence and the number of children. The patients look distinguished, appear calm and the inner tensions affect the smooth muscles mainly. Because of identification with authority figures the patients strive for authority, are skillful in arguments but do not express their feelings readily. The coronary occlusion usually occurs when their picture of themselves is threatened.

Patients with the anginal syndrome resemble those with coronary occlusion in many respects except perhaps for the difference in emphasis. Their general educational level is higher although the completion of educational units is not as frequent as in patients with coronary occlusion.

Rheumatic disease was studied in two parts, the first one covering rheumatic fever and the second rheumatic heart disease. The most striking feature is the common ecological background of these patients who frequently come from the lower middle class income group. Their past health has been poor and family history of heart disease, nervousness and sudden death is the rule. Three distinctive types were established by the study:

Type A Rheumatic Fever: No heart involvement but may have arthritis. They are more aggressive and spontaneous than the other groups.

Type B Rheumatic Fever: May or may not recover from the first attack. They are extratensive and passive.

Type C Rheumatic Heart Disease: Patients are usually not aware of having had rheumatic fever. They are repressed, passive and submissive. Other characteristics of this group are smooth, untroubled faces, anxiety just below the surface but little skeletal tension. However, they are timid and lack in confidence. Dunbar believes that there is a psychosomatic predisposition to this disease.

Cardiac arrhythmias show a high incidence of previous illnesses. The family history of cardiovascular disease is very prominent also. They are sensitive people and react with manifest anxiety and tension; they are making an effort to please and attacks occur when hostility is aroused while the cardiac irregularity increases the fear. This personality pattern is supposed to be very constant.

Patients with diabetes have a high intelligence level and good health record; male patients frequently remain unmarried. They are very distant and reserved, fluctuate between friendliness and suspiciousness and their indecisiveness is very pronounced. The initial reaction to their illness is one of extreme helplessness.

In the concluding chapter of her book Flanders Dunbar stresses the need for further study of specificity; she points out that her book contains much detail so that the reader can study the material and

arrive at his own conclusions. Yet, since her observations were made on patients at random, she considers the findings significant enough to serve as a basis for further investigations.

Two more publications by Dunbar deserve mention here, the book on "Emotions and Bodily Changes"⁴ and an article named "Character and Symptom Formation."⁵ They include statements and quotations of spontaneous accounts given by the various patients which are particularly interesting and illuminating. The accident-prone patient is likely to say: "I always have to keep working. I can't stand around doing nothing. When I get mad I do not say anything—I keep it in and do something." The hypertensive patient says: "I always have to say yes. I do not know why. I am always furious afterwards." The arthritic patient says: "Everything I do hurts me but I have to keep on moving."

The book by Weiss and English which was quoted on a previous occasion deserves more detailed mention because of an apparent popularity that this text is enjoying, particularly among non-psychiatrists. Their book, "Psychosomatic Medicine" is primarily destined to be used by the general practitioner or other medical men not specially trained in psychiatry. As a result of the authors' rather broad view, one is left with the impression that psychosomatic medicine covers almost every field in medicine. There are chapters on schizophrenia, pruritus ani, manic-depressive psychosis, military medicine, exhibitionism, epilepsy, frigidity, contraception, chronic appendicitis and others.

One might ask the question why and how psychosomatic medicine has obtained its present degree of popularity. There is little doubt that the advances made in psychopathology and dynamics, especially the understanding of unconscious emotional processes, have stimulated the psychiatrist to expand his field of application of the new knowledge. There is, however, perhaps another more significant factor which prepared the field for the expansionist trends of the psychiatrist. Medicine has experienced an unusual degree of mechanization during the past two decades which was in part due to improved diagnostic methods in form of laboratory procedures. As a result of this development, the doctor's task of treating a patient has become increasingly more depersonalized. It is also probably no coincidence that the popularity of psychosomatic medicine is running parallel with the increasing trend of specialization in medicine which has the tendency not only to separate mind from body but to subdivide body into several regions and parts. But where is this new medical discipline heading? Are the psychiatrists reorienting the practice of medicine and practically usurping it in the process? These are questions very likely to be asked by the practitioner who is bound to feel uncomfortable about such encroachment upon his field.

There are, in general, six groups of disorders which

might be classified among psychosomatic diseases, i.e., where the relationship of emotion and body expression is apparent:

- Group I. Somatic expressions of anxiety.
(tachycardia, nausea)
- Group II. Somatic defenses against anxiety.
(hysterical paralysis, fatigue)
- Group III. Somatic disease, seemingly related to personality factors and emotional conflicts.
(Peptic ulcer, hypertension)
- Group IV. Somatic disease directly produced by emotional factors.
(Self-inflicted wounds, violation of diabetic regime)
- Group V. Somatic disease influenced by emotional factors.
(Tuberculosis, chronic illness)
- Group VI. Somatic disease influencing behavior.
A. Diseases of C.N.S. (arteriosclerosis)
B. Other parts of body (blindness)

Following the above classifications it is apparent that patients of Groups I and II belong to the realm of the psychiatrist primarily. He may also be called upon for assistance in the treatment of patients of the remaining four groups depending on how significant emotional factors are in the production of the disease, in its perpetuation or resulting from it. However, they are always present in some degree and their recognition and treatment, if mild, will fall upon the lot of the non-psychiatric medical practitioner. The same applies to the handling of mild cases of Group I.

In other words, psychosomatic medicine means medicine which includes psychiatry and this points up the need for improved teaching of its principles and application in medical school. If properly carried out, study of personality will some day become as much a routine procedure in a patient's examination as is auscultation of the chest today. Improvement of the psychiatric acumen of the medical student will

make superfluous such artificial terms as psychosomatic. To be sure, continued investigation of specificity (Group III) may prove fruitful and should be carried on with unabated vigor. However, it is up to every doctor to learn how to handle simple psychiatric problems and to know when to ask for specialized assistance from the psychiatrist.

In summary, the present popularity of the psychosomatic concept is an indication of the need for better psychiatric education of the doctor.

BIBLIOGRAPHY

1. Hinsie, L. and Shatzky, J., *Psychiatric Dictionary*. Oxford University Press, New York, 1940.
2. Saul, L. in *Hunt's Personality and the Behavior Disorders*, p. 269, The Ronald Press Co., New York, 1944.
3. Dunbar, H. F., *Psychosomatic Diagnosis*, Paul B. Hoeber, New York, 1943.
4. Dunbar, H. F., *Emotions and Bodily Changes* (second edition), New York, Columbia University Press, 1938.
5. Dunbar, H. F., *Character and Symptom Formation*, *Psychoanalytic Quarterly*, 8:18-47, 1939.
6. Weiss, E. and English, O. S., *Psychosomatic Medicine*, W. B. Saunders Co., Philadelphia, 1943.
7. Alexander, F., *Fundamental Concepts of Psychosomatic Research*, *Psychosomatic Medicine* 5:3, 1943.
8. Deutsch, F., *The Use of the Psychosomatic Concept in Medicine*, *Bulletin of The Johns Hopkins Hospital*, 53:71, 1947.
9. Deutsch, F., *The Associative Anamnesis*, *Psychoanalytic Quarterly*, Vol. 8, 1939.
10. Cobb, S., *Borderlands of Psychiatry*, Harvard University Press, Cambridge, 1943.

SCIENTIFIC PROGRAM
SOUTH CAROLINA MEDICAL ASSOCIATION
OCEAN FOREST HOTEL
MYRTLE BEACH, S. C.
MAY 17, 18, 19, 1949

WEDNESDAY, MAY 18th

9:30-10:00 A. M.	Preliminaries
10:00 A. M.	Paper Dr. W. L. Pressly, Due West
10:30 A. M.	President's Address Dr. R. B. Durham, Columbia, S. C.
11:00 A. M.	Paper Dr. T. A. Pitts, Columbia, S. C.
11:30 A. M.	Paper "Some Difficulties in the Diagnosis of Coronary Artery Disease" Dr. John A. Boone, Charleston, S. C.
12:00 Noon	Guest Speaker "Carcinoma of the Endometrium" Dr. Edward B. Sheehan, Boston, Mass.
1:15 P. M.	Alumni Luncheon
3:00 P. M.	Paper "Carcinoma of the Uterus" Dr. J. R. Young, Anderson, S. C.
3:30 P. M.	Paper "Problems in Treating the Alcoholics" Dr. W. R. Mead, Florence, S. C.
4:00 P. M.	Guest Speaker "Treatment of Fractured Ribs" Dr. F. P. Coleman, Richmond, Va.
7:30 P. M.	Annual Banquet
10:00 P. M.	Dance

THURSDAY, MAY 19th

9:30 A. M.	Paper Dr. William Weston, Jr., Columbia, S. C.
10:00 A. M.	Paper "Obstetrical Lessons from Studies of Maternal Mortality" Dr. J. Decherd Guess, Greenville, S. C.
10:30 A. M.	Guest Speaker "The Management of Some Usual Obstetrical Difficulties" Dr. H. Hudnall Ware, Richmond, Va.
11:30 A. M.	Paper "New Concepts in the Management of Cerebral Palsy" Dr. Weston Cook, Columbia, S. C.
Noon	Adjournment

PROGRAM OF SOCIAL EVENTS**Annual Meeting****Tuesday — 8:30 P. M.**

Special entertainment—

(All of the members of the Association and their wives are invited to enjoy this occasion which will consist of a floor show, general dancing, and simple refreshments.

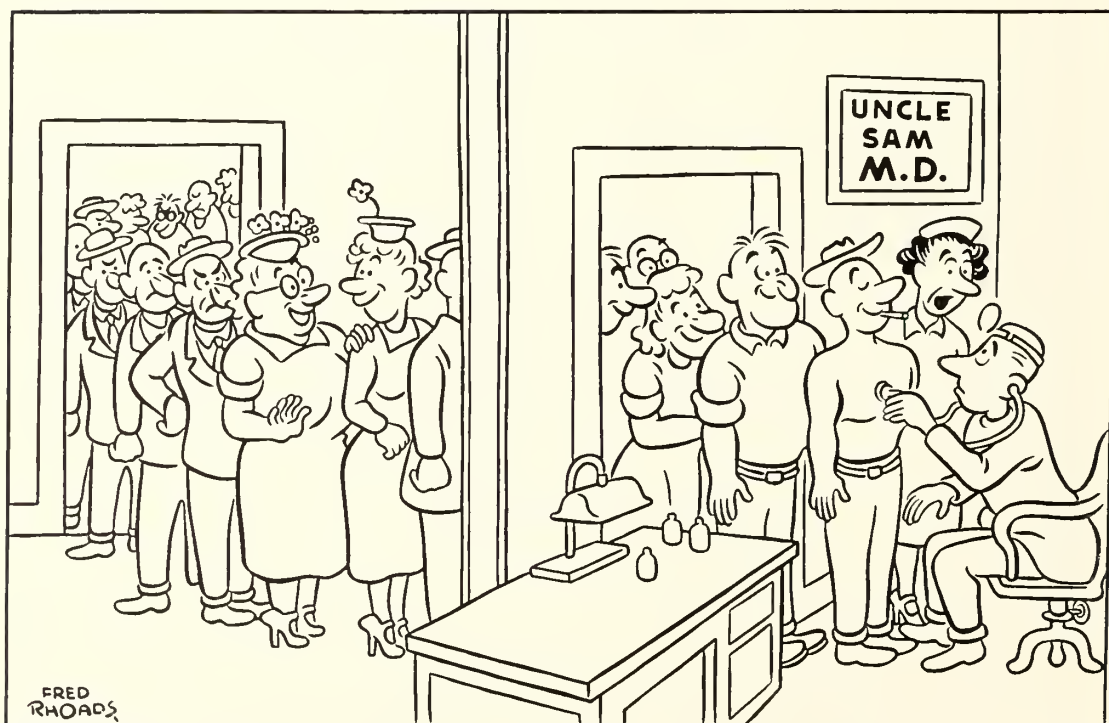
The Association will be the guests of the Liberty Life Insurance Company, (Greenville, on this occasion.)

Wednesday — 1:15 P. M.

Annual Luncheon of Alumni Association (Medical College of S. C.)

Wednesday — 7:30 P. M.

Annual Banquet of South Carolina Medical Association.



"YOU'LL HAVE TO HURRY, DOCTOR—THOSE AT THE END OF THE LINE ARE GETTING IMPATIENT."

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price			Florence, S. C.		
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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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Subscription Price	\$3.00 per Year

APRIL, 1949

NEW LEADERS

In addition to hearing the reports of its officers and committees, and planning its activities for the year ahead, the House of Delegates is entrusted with the highly important task of choosing its leaders for the future.

If we read the times aright, the days ahead are fraught with heavy responsibilities for our Association. We contend that the best interests of our people can be met by an improvement and amplification of our present free system of medical care—and it is incumbent upon us as an Association to assume the leadership in this expansion and development. We have put ourselves “on the spot,” and it is up to us to either put up or shut up.

In any organization which functions there must be leaders—and the work of the leaders will in large measure determine the attainments which are achieved. This is certainly true of our Association.

We would do well to bear this in mind as we choose our leaders at the coming session at Myrtle Beach.

HOUSE OF DELEGATES

The House of Delegates will convene at 11:00 A. M. this year instead of at the usual hour of 2:00 P. M. With several important matters up for discussion and decision, it is essential that ample time be available for business, and this is the reason for the earlier hour.

All delegates are asked to present their credentials at the door before eleven o'clock so the meeting can start promptly.

COUNCIL

Council will hold its annual meeting on Monday, May 17. All matters to be considered by Council should be presented to the Chairman, Dr. O. B. Mayer, before that time.

A MEETING PLACE

There was a time when our Association could hold its annual meeting in any of a number of places in

the state. As we look back over the history we find accounts of meetings in such communities as Anderson, Greenville, Sumter, Spartanburg, Florence, Camden and Rock Hill. But such is not the case today. There are only three places with ample hotel facilities to house our members and their wives—Charleston, Columbia and Myrtle Beach.

Custom has decreed that the local society shall serve as hosts for the occasion. As a result the physicians of Charleston, of Columbia, and of the Pee Dee are being called upon with regularity to assume the responsibility for local arrangements, entertainment, etc. So far these physicians have accepted their role with true Southern graciousness, but we can easily see where it might become a burden and a chore.

An obvious solution to the problem would be for the Association itself to assume all obligations for the meeting and to merely entertain itself. But this would do away with much of the charm and friendliness of our annual sessions.

So we suggest another plan. Let those district or large county societies which cannot entertain the Association on its home ground invite the Association to be its guest at Myrtle Beach. This was done several years by the Greenville Society. After all plans had been made to hold the meeting in Greenville, unexpected developments arose which indicated inadequate hotel facilities. Immediately, plans were made to have the meeting at Myrtle Beach—and the Greenville physicians insisted on continuing as hosts of the occasion. The result—one of the most enjoyable sessions which we have had in recent years. What Greenville did others can certainly do.

We make the above suggestion not in any sense of criticism but rather as one solution to a difficult problem. We believe it can work and that it will mean much to our Association.

FROM OUR REPRESENTATIVES
IN CONGRESS

Two statements have come to our attention which should be of marked interest to the members of our

Association at this time.

The first was a telegram from Senator Olin Johnston to Mr. J. B. Harvey of Clover.

"We should concentrate on improving operations in existing institutions such as the Veterans Administration and public service hospitals rather than by expanding government medical facilities.

"The federal government can and should improve medical service to our people by subsidizing medical schools, research activities, and by aiding state and local governments to build better hospitals and clinic facilities, not by socialization of a profession which can never be made into a machine.

"Devotion to mankind as exemplified by our own Dr. Buck Pressley will do more to improve the health and welfare of our people than all the compulsory medical insurance plans in the world."

The second statement was in the form of a letter from Representative Hugo S. Sims to Mr. G. Werber Bryan, Sumter.

"As you undoubtedly know, I do not advocate nor favor socialized medicine. The doctors who talked to you were possibly misinformed by others who are afraid that I may vote for a health insurance plan. I realize that the average farmer, small businessman and working man are not able to afford adequate medical attention. I have informed a number of doctors by letter that I am inclined to go along with a health insurance plan if the medical profession continues to refuse to do anything to meet this basic need of the masses. Doctors will, of course, oppose a health insurance plan because it hits the pocketbook. They will attempt to smear anyone who votes for such a plan as one who favors socialized medicine. They will say that this is the first step toward socialized medicine. If the medical profession continues to refuse to meet this basic need and government action of some kind, such as health insurance, becomes necessary, I believe that I can convince the masses of the people in the Second District that I am right. I hope you will help me."

REPORT ON NATIONAL HEALTH CONFERENCE

The Fourth Annual meeting of the National Conference on Rural Health held at the Palmer House in Chicago February 4th and 5th, 1949, was by all odds the most successful conference thus far held. Two factors contributed to its success. First, the pre-conference meeting of the State Chairmen and Committeemen the day before the conference and second, the panel-type conference that was held.

As usual, The National Conference on Rural Health was composed of physicians, educators, public health workers, and a liberal number of laymen representing the consumer group. It was earlier found out that the success of these conferences depended largely upon the farm folk being well represented—and they were.

The health programs of National Farm Organizations were ably discussed by representatives from the Milk Producers Federation, The Grange, Farmers Cooperative Union of America, and The American Farm Bureau Federation. It was significant to note that these large and powerful farm groups were not in favor of compulsory health insurance. These farm groups have health programs and health committees that are active. They are interested in health legislation and have health directors.

Dr. DeTar of Michigan described a State Rural Health Committee in action—that of his own state, Michigan, which undoubtedly must be the most active in the United States.

They have a placement bureau for doctors in rural areas, giving them all the desired information about locations. Have obtained more money for medical schools. Set up a State Health Council with an executive director and a budget of \$22,500.00. Organized County Health Councils to become part of State Council. Distributed 25,000 brochures on health to schools of State. Set up health guidance and dental care clinics. Health surveys made at a cost of \$12,000.00, radio broadcasts at \$12,000.00, and a health picture made at a cost of \$14,000.00. Has a mediation com-

mittee which handles complaints between patients and doctors (fees, services, etc.).

The main thing he didn't say was where and how he got the money to do all these things.

Dr. Mulholland of Virginia gave a fine discussion on animal diseases affecting humans. Brucellosis seems to be the most important at the present time.

Dr. Darley, of the Colorado School of Medicine, speaking on the general practitioner in rural medicine pointed out that there is a gap between what we know and what we do (medical knowledge and medical service). Having to see so many patients per day cuts into the physician-patient relationship. He further stated that any insurance plan (voluntary or compulsory) dilutes the physician-patient relationship by bringing in a third party—the insurance agency. He believes that boards of certification by Army, Insurance Companies, Public Health, Veterans Administration, etc. weakens the position of the general practitioner.

The conference was divided into five round table discussion groups. Since I could attend only one, I picked the group discussing cooperative health programs for rural areas. There was a lively discussion about local health units—what they should comprise to function properly and the fact that they should serve at least 25,000 people to function economically. It was unanimously agreed that local health councils could play a definite and vital part in bringing about better health conditions for the people it served. These councils could serve as a medium for bringing together all health agencies to work together in solving their problems.

The pre-conference meeting took up important problems dealing with rural health. THE MEDICAL SCHOOL AND RURAL PRACTICE was the first problem discussed and which brought out these facts: That many states are now giving scholarships to students who will later go to rural areas of that particular state to practice medicine. Some medical schools were requiring a scholarship of 95% or above to be eligible. However, they found that some differential had to be

made for those students coming from rural sections; so this figure was dropped to 87%.

Many students after completing their medical courses felt that they should go on to some specialization rather than general practice. Medical schools are crowded to capacity and a higher percentage are specializing, although, some see a slight increase in the past year of more doctors going into rural and semi-rural areas.

In regards to hospital development and improvement—several brought out the surprising fact that many communities were able to build hospital facilities, suitable to their needs, by voluntary community effort cheaper than they could build under the Hill-Burton program. They found that building according to government requirements and specifications, the cost was so great that they could leave off the government's one-third help and build according to their needs much cheaper. Most every one was in accord that rural health centers were of definite advantage for the betterment of rural health. However, it was emphasized that it should be kept separate from private practices. That is, that doctors in private practices should not have their private offices in these centers. These centers should be strategically located, adequately staffed with nurses, technicians and equipment to take care of the community's needs as regards preventive and curative medicine.

In the distribution of Physicians, Dentists, and Nurses to rural areas, the responsibility is just as much on the communities needing them as it is on the medical profession. A community with poor roads, poor schools, little or no community life and cultural facilities, rightfully, has a poor chance to get a physician and a dentist to locate there. A professional man who has spent about half of his normal life expectancy preparing himself at great expense to practice medicine is not apt to isolate himself in such a community if he can prevent doing so. He owes it to himself and family to have more suitable surroundings and facilities to spend his professional life.

LOCAL HEALTH UNITS IN RURAL AREAS.
In the distribution of local health units it should be borne in mind that they should be placed so as to serve the most people adequately. A health unit to be run most efficiently from an economical standpoint should serve at least 25,000 people. There should be a closer and more harmonious feeling between the local health officer and private practitioner. School health programs should be emphasized. Teachers should be taught to look for defects in children. There should be some method for screening defects among school children. Then, those with defects should be sent to the family doctor or specialist, as needed, for treatment. All first year children should be given a physical examination.

Rural community health programs should be supported. Most all rural organizations have a health program or at least a health committee. These working together should accomplish much towards solving health problems of the community.

EXTENSION OF MEDICAL SERVICE THROUGH VOLUNTARILY PREPAYMENT PLANS IN RURAL AREAS.

A survey of pre-payment plans in rural areas reveals these highlights: (1) shows that the ratio of medical society prepayment plans which extend rural enrollment privileges is higher than that of the consumer-sponsored programs because the consumer-managed plans are often created to serve the desires or needs of a particular consumer group. (2) that medical society approved and/or Blue Cross coordinated plans are exerting increasing efforts to reach those in rural areas as well as those who are self-employed and therefore are not eligible to enroll through the employer-employee group. (3) that underwriting agencies need cooperation and support of rural groups.

It is estimated that over 52 million people in the United States are covered by Hospital Insurance through Insurance Companies, Hospital Companies, Fraternal Societies, Blue Cross and other organizations. Over 26 million are covered by surgical insurance and about 9 million by medical insurance. Judging from the experience of other countries in compulsory sickness insurance, it seems that voluntary prepayment insurance is medicine's answer for the extension of medical service to the rural areas.

Harold S. Gilmore, M. D.; Chairman,
Committee on Rural Health,
S. C. Medical Association

CORRESPONDENCE

March 5, 1949

Dr. Robert B. Durham, President
South Carolina Medical Association,
Columbia, S. C.

Dear Dr. Durham:

The beautiful red roses arrived yesterday and are a pleasure not only to me but to all who come in my room. The attention from the State Association at this time is sincerely appreciated. Will you please convey to the Members of the State Medical Association my appreciation of their kindness?

I have been undergoing a series of x-ray irradiations and the effect of the treatment is beginning to show in a lessening of severe pain. Everyone has been kind and sympathetic in their interest. At a time like this a person who is ill, appreciates very much such things.

With every good wish for the success of your efforts as President and with warm personal regards, I am

Sincerely yours,

R. S. Cathcart

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March 10, 1949**

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THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

FEDERAL SPENDING AND COMPULSORY SICKNESS INSURANCE

If not the best, perhaps the most practical and easily understood argument against the enactment of legislation for compulsory sickness insurance on a national scale, is the huge cost that would be involved. Much has already been written on this subject but, in our opinion, not enough. The public simply does not realize what it faces and the extent to which the burden will be borne by every taxpayer.

Senator Daniel A. Reed of New York, recently discussed at length the present wasteful expenditures of Government, and called attention to the vast amount of public funds being poured down the drain to no useful purpose at all. His remarks were not directed specifically at the proposals for compulsory health insurance and, therefore, so far as this issue is concerned, may be considered as of more value than had they been tinged with a partisan hue. Nevertheless, the facts to which he called attention, as reported in the Congressional Record of February 8, 1949, had better be taken into consideration by those who propose the launching of such a vast program.

Senator Reed quoted the statement of Comptroller General Lindsay Warren, former Congressman from our sister State of North Carolina and for many years Chairman of the Committee on Accounts and Expenditures of the House of Representatives:

"The Federal Government is a hodge-podge and crazy-quilt of duplications, over-lappings, inefficiencies, and inconsistencies * * * It is an ideal system for tax eaters and for those who wish to keep themselves attached to the public pay roll, but it is bad for those who have to pay the bill * * * What we must be after is this monstrous Frankenstein, created in the name of bureaucracy, and already in some instances becoming bigger than Congress, its creator."

From \$5,143,000,000 in 1933, the expenditures of the Federal Government increased to \$40,180,000,000 in 1949. During the same period, civilian personnel employed by the Federal Government increased from 564,000 to nearly 2,100,000.

A Joint Committee on Reduction of Non-essential Federal Expenditures reported in 1946 over 900 instances of duplication and over-lapping among the bureaus, agencies and departments of the Government. 65 agencies were engaged in gathering statistics, 34 in acquiring land, 12 in home and community planning, 14 in forestry, 28 in welfare, and 16 in wildlife preservation.

There are 61 separate Government printing and duplicating plants in Washington, 23 in San Fran-

cisco, 25 in Philadelphia, 16 in Chicago and New York each, and a number of others.

Some idea of the waste and expense of these establishments is conveyed in the fact that an estimated \$55,000,000 is spent annually for printing and publications, exclusive of forms and reports. "Tons and tons of *unsold and undistributed* publications are sold each year as *waste paper* for \$38 a ton."

According to a survey by the House Appropriations Committee's investigative staff in 1947, the Bureau of Internal Revenue, in 1946, printed 500,000,000 tax forms and 115,000,000 instruction sheets to supply 47,000,000 tax payers.

The Government recently found that it owns 3.6 typewriters for every Federal employee who uses one either full time or part of the time.

The Commission on Reorganization of the Executive Branch (The Hoover Commission) reported that by applying modern business methods, about \$250,000,000 could be saved annually in Government purchasing, and inventories reduced by \$2,500,000,000 by applying modern business methods.

The Commission reported further that half of the 3,000,000 purchase orders by Federal Government Civilian Agencies are for purchases amounting to \$10 or less, and that it costs the Government more than \$10 to perform the paper work alone on each of these purchasing orders.

The War Assets Administration sold a building to private interests who immediately offered to lease the space to the Government Printing Office which was in need of additional storage space at a rental which would pay for the entire purchase price within a few years.

Finally, and to cap the climax, Senator Bridges reported that after the Army tore down a multimillion dollar camp in Alaska and shipped the lumber out, the Interior Department bought it and shipped it back to a point in Alaska within ten miles of the place where the Army Camp had been.

Of course these are only a few of the many instances reported and unreported.

This observer for one, does not entertain even a faint hope of the possibility of ever achieving the operation of Government on a purely business basis. It simply is not in the nature of things. Government, being the creature of politics, operated by politicians, constitutionally is not susceptible of that type of operation.

But there must be a limit beyond which such waste cannot go without completely undermining the structure of Government. The addition of hundreds of thousands of employees, the printing of millions of pamphlets, regulations, forms; and setting up of nu-

merous offices with necessary equipment in every county of every state in the Union, as would be required to administer a nationwide compulsory sickness insurance system, would entail such additional waste and unnecessary expense as might well prove to be the final blow to Democratic Government.

FAMILY DOCTOR OF THE YEAR

(Extension of remarks of Hon. James B. Hare of South Carolina, in the House of Representatives. Printed in the February 15, 1949, issue of the Congressional Record.)

Mr. HARE. Mr. Speaker, each year the American Medical Association selects one of its own number as "the American family doctor of the year." This selection is made on the basis of a doctor's contribution to the health and welfare of the community he serves—that is, the association selects the physician who, in the opinion of the association, has rendered the greatest, most efficient, and outstanding medical service to an American community.

On December 2, 1948, the honor of being selected the "family doctor of the year" was bestowed upon Dr. William Lowry Pressly, of Due West, S. C. I know Dr. Pressly personally, and I know the American Medical Association made no mistake in its selection. In fact, I wish to congratulate the association for its recognition of a great American.

Dr. Pressly is a graduate of Emory University, and I include herein an article appearing in the January issue of the Emory Alumnus.

From the Emory Alumnus:

"Buck" Pressly Quit Baseball to Become
"The" Dr. Pressly

Thirty-three years ago, or back in 1915, "Buck" Pressly was a man of two considerable, widely varying talents, and he had to choose between them.

He was a professional baseball player, good enough to have earned \$5,000 a year at the sport and to have been tendered (and rejected) a major-league contract. But he also had devoted 3 years' time, effort, and money to getting his doctor of medicine degree and three other years to internship and residency.

"Buck" Pressly chose medicine, and after netting \$750 in his first year of practice, began to wonder "how I had come to make such a big mistake." Now he knows.

On December 2, 1948, his sixty-first birthday anniversary, Dr. William Lowry Pressly, 12M, that same "Buck" stood before the delegates to the convention of the American Medical Association in St. Louis, Mo., to receive one of the most meaningful and prized honors open to a man of medicine: the gold medal award as "family doctor of the year."

Dr. Pressly, who for all these last 33 years has been living in and practicing in and around the little college town of Due West, S. C., came within a whisker

of getting the award a year ago, the first time it was offered. Then, though, he had been ranked as No. 2 in a field of 200 physicians nominated for the honor.

If the AMA had not placed Dr. Pressly at the top this year, it would have had the entire South Carolina Medical Association to contend with, for it was that group which nominated and backed him both years. More specifically, it was another Emory alumnus, Dr. Horace Whitworth, 38M, of Greenville, which is due north of Due West, who first suggested him as a candidate.

"His winning was really a great thrill to me," said Alumnus Whitworth, who is secretary of the Greenville County Medical Society. "I kind of started the whole thing and have watched it grow and have been close to the collection of data. When the AMA first wrote us about having such a selection, I began thinking about 'Dr. Buck' as a man who could win."

Especially does joy reign in little Due West, where Alumnus Pressly is first citizen and a little of everything else. It is particularly proud that not only has he done all his practice there but was born and reared there, attended college there, and in all his life has left there only long enough to get a medical education.

There are those of Due West's citizenry who recollect the good doctor's horseback and horse-and-buggy days, but there are more who know that he has worn out some 24 automobiles in caring for them. In the course of his practice, he has delivered 4,200 babies, several times the total present population of his town.

Many's the patient he's taken to the larger centers of Anderson, Abbeville, and Greenville in his own car for treatment. He has often accompanied them to farther-removed places like Duke University, Boston, or Baltimore, remained with them until after serious operations, then returned to his home by plane.

It's only the complicated cases which require treatment elsewhere, though, for "Dr. Buck" by now well set up to handle most ailments—he and his well-equipped clinic with a staff comprising another general practitioner and a pediatrician, two nurses, a maid and an orderly.

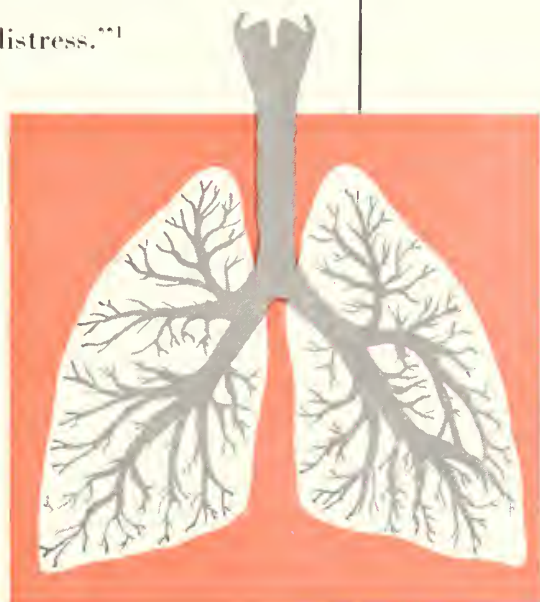
"He's just a born doctor," says one neighbor. "He's either in his office or out among his patients from 7:30 each morning until about 10 at night, when the last patient is treated in the office. In addition, I believe he is called out of bed at least half of the nights."

The wonder is that Dr. Pressly ever gets to bed, with all he takes on. Besides his general practice, which is at least a two-man job, he is physician for Due West's Erskine College and its athletic teams and surgeon for the Southern Railway. Furthermore, he serves as licensed pharmacist for the drug store in the nearby village of Donalds, which is too small to support a pharmacist.

Too, he is known in his region as "the father of pub-

paroxysmal dyspnea...

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE



1. Murphy, F. D.: Treatment of Cardiovascular Emergencies in the Home. Wisconsin M. J. 42:769 (Aug.) 1943

lie health," a title which originated when, as a young doctor, he went throughout his county vaccinating against typhoid fever at his own expense all who would let him. That was during a rampant epidemic and marked the beginning of free immunization in his area. Typhoid now is almost unknown there.

He also has sponsored well-baby clinics. But these are only his medical activities. On the side, Dr. Pressly for 26 years has been a trustee of Erskine, from which he received his A.B. and where his father taught ancient languages; for 20 years, a deacon in his church, and for 18 years, a member of the Due West School Board.

He has promoted the organization of a Boy Scout baseball league and the importation of high-grade beef cattle and hogs into his county; has been active in organizing the Grange and erecting its building, in obtaining better schools and improved medical service for the Negroes of his community, and in organizing a community service club. In World War I he went away briefly to serve as an Army medical officer; in War II he stayed home and held a variety of jobs, among them that of assignment and procurement officer for medical men in South Carolina.

Long ago the ability, energy, and willingness of Alumnus Pressly became known to doctors far beyond the bounds of Due West. He is, or has been, for instance, a member of the AMA Council on Medical Education; chairman of the Southern Medical Association's section on general practice; and president of his State, district and county medical associations and societies.

Dr. Pressly in 1909-1912 attended the Atlanta College of Physicians and Surgeons, which a few years later was merged into the Emory University School of Medicine. A catcher on the college baseball team during his undergraduate days at Erskine, he continued to play ball in the summers during his medical school years—but on a professional basis.

Beginning as first baseman for the Roanoke club of the Virginia league, he became playing manager after his first year and in 1912 the Pressly-run team won the league pennant. His \$5,000 manager's salary looked good, especially in those days.

But after interning in Roanoke's Jefferson Hospital, he came back to Due West in 1915, and in June of that year married a Roanoke girl, Miss Elma Lipscomb. She died in September 1948. Everybody in Due West, of course, knows Dr. Pressly, and everybody has for decades. To them he's either "Dr. Buck" or "Buck." He's so well known that, to quote Dean of Women Elizabeth Nickles, of Erskine, "I would say he's cured as many with his infectious smile as with his medical skill."

Along with his nomination there went to the AMA a vast stack of letters from "Dr. Buck's" home-town friends, white and colored.

And when he came back with his award there awaited him hundreds of congratulatory messages

from South Carolinians, from medical men and from Emory.

One of the most appropriate comments came from a close and long-time friend, Dr. W. Thomas Brockman, of Greenville, who said: "I can say 'Buck' has brought to South Carolina her greatest medical honor and it is our hope that the general practice of medicine will become more popular because of him."

Emory, which is doing its best to encourage the general practitioner, hopes so too.

ACTIVITIES

The Public Relations department of the South Carolina Medical Association is currently engaged in:

1. Issuing weekly news releases to the weekly and daily press of the State—some eighty-odd newspapers, of which about 15% are dailies and the others county publications, issued once a week to subscribers in small communities and rural areas.
2. Keeping in regular contact with the South Carolina Legislature in the interest of the medical profession of the State.
3. Issuing Legislative Bulletins to keep the members of the Association informed of developments in the State and National Legislative bodies.
4. Assisting the committee in charge of organization of the Surgical and Obstetrical Care Plan.
5. Conducting and participating with a Speakers' Bureau (which was organized by the Department), supplying speakers for civic organizations and other groups throughout the State on Compulsory Health Insurance and related subjects. To date 20 speeches have been arranged for and all requests have been filled.
6. Enlisting the aid of the physicians in the State, through the local public relations committees, in securing support of constructive legislation, and directing the course of the effort.
7. Working through the public relations committees to secure the cooperation of the physicians in the general effort toward improving the profession's public relations, and educating the public on proposed compulsory health legislation.
8. Arranging a series of weekly and other radio programs.
9. Issuing quarterly the Auxiliary Bulletin of the South Carolina Medical Association.
10. Preparing monthly the Ten Point Program Department of the Journal.
11. Assisting the committee on the practice of Naturopathy in the effort to find the solution to that problem.
12. Assisting Dr. Harold Gilmore, Chairman, and his Committee on Rural Health, in starting the work of the State Health Council, with the

organization of which this department was actively engaged.

13. Keeping informed of the activities of other State Medical organizations and the American Medical Association, and coordinating our work with theirs wherever possible.
14. Supervising arrangements for the commercial exhibits at the annual meeting at Myrtle Beach in May. The spaces have been sold for several months and 90% of the money collected.
15. Discussing the issue of socialized medicine, anywhere, everywhere, formally, informally, individually and before gatherings large and small, and, generally, taking on the chin at social and other occasions, the criticisms and complaints against the profession which many of your friends and associates have on their chests but do not express to "their doctors" but which, they say, describe the reasons why "socialized medicine" may come to pass.

In addition to the foregoing and other Public Relations activities, the office is also that of the legal counsel, and furnishes legal advice to the officers and members of Council, when called upon. Such instances are increasing and involve a responsibility which cannot be taken lightly, or without sufficient preliminary investigation.

The results of these and our other efforts are not always—nor even generally—tangible. But they are none-the-less real.

And for their success, understanding, willingness to accept suggestions on matters outside the scope of medical training, and active cooperation on the part of the individual physician are essential.

WORK ON SURGICAL CARE PLAN PROGRESSES

The Committee charged with the task of working out the tentative fee schedule for the Surgical and Obstetrical Care Plan is continuing its study under the leadership of Dr. J. Decherd Guess of Greenville, Chairman.

Since the last issue of the Journal further schedules in use by Plans in neighboring states have been examined, and the Committee plans another meeting soon for the purpose of reaching more definite conclusions with respect to its recommendations to be made to Council for submission in turn to the House of Delegates in May.

The seven lay members suggested for recommendation as members of the Board of Directors have been approached on the subject and have indicated their interest and willingness to serve if elected.

NATUROPATHY

After considering at length the report and recommendation of the Committee on Naturopathy, Council, on Wednesday, March 16th, approved support of a

Bill to repeal Section 5231-25 of the 1942 Code of Laws, the portion of the law which permits the Naturopathic physicians to practice obstetrics and gynecology, and use of biologicals.

Such a Bill (H.1440) was introduced in the House of Representatives on March 23rd by Mr. Jackson, of Sumter County, Mr. Davis of Anderson, and Mr. Cartwright of York. Copies were immediately mimeographed and mailed to all members of the Association, with the request that they contact their Representatives and explain to them why the best interests of the public require the passage of such a law.

The Bill was referred to the Committee on Military and Public Affairs, where it remains as this is written, the Committee not yet having had opportunity to act upon it.

Council had previously expressed its approval of the measure to increase the authority of the Board of Naturopathic Examiners to revoke licenses of their practitioners.

BLUE SHIELD PLANS EXCEED TEN MILLION MEMBERS IN 1948

With a fourth quarter gain of 1,057,274 members, the largest quarterly growth in the history of the prepayment medical care movement, Blue Shield national headquarters announced recently that 1948 enrollment had totaled 10,370,819 persons. The million-member gain represented a growth of 11.3% for the fourth quarter of 1948.

Contributing to this phenomenal growth was the enrollment of Ford Motor Company employees, totalling approximately 250,000 persons, the majority of which were enrolled in Michigan Medical Service.

Blue Shield in Michigan continues to be the largest Plan in the nation with a December 31st enrollment of 1,311,811, followed closely by Blue Shield in New York City with 1,128,967 persons enrolled.

Although still relatively modest in size, Pennsylvania's Blue Shield Plan experienced one of the most rapid enrollment gains during 1948, increasing its membership 171% for a new total of 353,643.

Blue Shield Plans in Indiana, New Jersey, and Kansas City, Missouri went over the 200,000 member mark during the latter part of 1948.

Delaware still leads all other Plans in the percentage of population protected, having enrolled approximately 49% of the state's population, Michigan follows with 21% of the population enrolled.

Blue Shield growth for 1948 showed a 43.39% net gain over 1947, with an addition of 3,138,628 members during the year.

Although Blue Shield Plans vary considerably in the scope of benefits offered and the corresponding cost to subscribers, a recent survey conducted by the Blue Shield national office produced, among other things, a description of the average Blue Shield Plan.

Such a plan provides complete surgical and ob-

stetrical care including delivery, fractures and dislocations, medical care for hospitalized cases, limited diagnostic x-ray, and anesthesia.

These benefits are provided on a service basis for single subscribers with annual incomes less than \$2050 and families with incomes less than \$3100.

Average subscription costs are \$1.17 per month for the single subscriber, \$2.26 for a man and wife, and \$2.75 for the family.

Most comprehensive in benefits offered and also highest in cost to the subscriber is the program offered by Oregon Physicians' Service, which includes home and office visits by the doctor and limited dental services, the family cost running as high as \$8.10 per month.

Least expensive is the surgical certificate offered by United Medical Service in New York City, starting at 40c per month for the single subscriber.

BLUE SHIELD PLANS ASKED TO COOPERATE WITH AMA NATIONAL EDUCATION CAMPAIGN

Blue Shield Plans have been urged to cooperate with the American Medical Association's recently organized National Education Campaign by accelerating their enrollment efforts during 1949.

Appearing before the January meeting of the Blue Shield Commission, Mr. Clem Whitaker and Miss Leonne Baxter indicated that enrollment in voluntary plans would comprise a major emphasis in the campaign as it gained momentum.

To explore specific ways in which enrollment in Blue Shield might be boosted during the coming year, staff members from the office of Whitaker and Baxter met on February 13, in Chicago with the Blue Shield national committee on public relations.

Proposals for assistance from Whitaker and Baxter in the preparation of promotional and public relations materials to be used by Blue Shield Plans were approved by the Blue Shield committee and will be presented to the Commission and 1949 Annual Conference of Blue Shield Plans on April 18-20 in Hollywood, Florida.

HISTORICAL SIDELIGHTS

THE RENAISSANCE AND SOME RENAISSANCE DOCTORS (1348 or 1453 — 1530 or 1600)*

R. M. POLLITZER, M. D. #
Greenville, S. C.

The Renaissance took place in Europe, chiefly in Italy, France and Germany during an era which cannot be exactly delimited. During this age, art, science, medical science and learning made rather sudden and marked progress.

What is meant by the word renaissance? Literally renaissance or renaissance means simply rebirth. The word is used "to denote the whole transition from the Middle Ages to the Modern World." Man discovered himself as a part of the world. And indeed after a long period of semi-darkness, or at least lack of progress in various branches of knowledge, there were many valuable contributions. It was as though there had been scattered some yeast or catalyzer.

Of course we do know that the printing of books begun in 1454 by Johannes Gutenberg, had a tremendous influence. But just as important was the sudden irruption of many learned Greek refugees who fled from Byzantium or Constantinople as the Turks

took their great and ancient city in 1453. They poured into Italy bringing few good, but a wealth of knowledge inherited from ancient Greece, the Levantine countries and many famous cities of antiquity.

At that time Europe knew nothing, or very little of Hippocrates, Plato, Celsus or any of the Greek or Latin writers, with whom today we are as close to, or even more akin than to Shakespeare or his contemporaries.

Further the invention, or at least the use of gunpowder lessened the value of castles to the nobles and thus caused feudalism to crumble. So towns became of greater significance; business of more importance; and the common man of greater consequence.

Another factor in introducing the Renaissance was the preparatory studies in anatomy, the beginnings of clinical observation, along with the rise of what is called Humanism in the late Middle Ages. Man, to some extent, now began to recognize his dignity, his individuality and his opportunity to investigate and even to create.

Martin Luther (1483-1546) in rebelling against the domination of the Catholic Church, although initiating religious wars and upsetting the status quo, did cause people to do some thinking and to dare to enter upon scientific investigation without fear of damnation.

The Ancient Greeks did not believe that illness was a punishment, but rather the result of disharmony with nature. We would say today that disease is un-

*William Gilbert in his book on magnetism (1600) used the word electricity for the first time. This marks the beginning of the modern age of science.

#Read before the Medical History Club; Charleston, S. C., Jan. 8, 1948.



R. U. Q.

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natural or abnormal. Therefore disease is not to be calmly accepted as a well deserved divine retribution. On the contrary, it should be avoided if possible, so one is justified in trying to prevent or to cure disease.

Further the world was no longer regarded as too temporary to enjoy, and the body too vile to study or even notice. Hitherto the Christian Church had insisted that man's whole thought should be on the celestial life, so nothing aside from religion could be worthy of attention. Indeed with the advent of the revival of learning it was as though winter's snow had melted and man again could see the fertile earth with all its vegetation.

Naturally Italy, that ancient land, once the center of the Roman Empire and later the seat of the Roman Catholic Church, first felt the stimulus of the new thought. There for centuries, universities had been attracting students, and the temperament of the people had rarely permitted them to do without the pleasures of life. They naturally turned to art and music. And lastly when Mainz in Germany was sacked by the troops of Adolph of Nassau in 1426, this caused the printers of that city to scatter over Europe. Three years later a book was printed in Italy. It was not long before many volumes, some of which were very beautiful and many of great value, were streaming from the printing presses of Florence, Venice and later Paris, Basel, London, Antwerp and Leyden.

To recapitulate, let me here quote from Victor Robinson, "Only when the Renaissance was in its maturity, could it be seen that the new art of movable type and paper-making, the discovery of America and the rounding of Africa, the decline of Scholasticism and the rise of Humanism, the impairment of Ecclesiasticism and the spread of the Reformation, the emancipation from authority and the re-awakening of the experimental method, had changed man's outlook on the world."

The Renaissance did not suddenly burst forth; Abelard already in the 12th century had attempted to show that scholastic disputes did not advance knowledge. Also Roger Bacon (1214-1294) in the 13th century had performed various scientific experiments, and he insisted that man should seek knowledge in the laboratory. According to H. C. Wells, Roger Bacon was of far greater importance than any monarch of his time.

Many men of great intellect lived in Europe between 1348 and 1600, the period under discussion. Of these the majority died leaving nothing to posterity. But here and there in one country or another, in some branch of science or art, one achieved distinction by his own individual work and gave us the record, so that in making his contribution to knowledge he left his own memorial.

In this remarkable period of history known as the Renaissance, there was a return to the ideas and ideals of the ancient Greeks in philosophy, art, literature and medicine. The Middle Ages had come to an end; men

began to invent and to discover; science and art were enriched.

It is not possible to name but a few of these celebrities and in order to conserve time, our biographical sketches must be brief.

Almost everyone who has the least knowledge of the history of art or science has come across the name of Leonardo da Vinci (1452-1519). This man who surely may be reckoned as one of the world's most illustrious was not a doctor, and so notwithstanding his pioneer work in anatomy and his influence on medicine, must be omitted from this paper. However, he should be credited with having dissected carefully thirty males and females of various ages.

Although we of today are not familiar with the name of Thomas Linacre (1460-1524), yet we should recall gratefully that he obtained from the king, Henry VIII in 1518 letters patent to found a society of London physicians. This later (1551) became the Royal College of Physicians. It was empowered to regulate the practice of medicine in London and to license practitioners throughout the kingdom. Also it could examine apothecary shops, read prescriptions, levy fines and even imprison. Dr. Linacre was the first president. He was born in Canterbury and after completing his studies at Oxford traveled and studied in Italy, graduating from Padua. At Bologna and Rome and at Florence his learning was recognized. While in Florence, Lorenzo de Medici had him share his son's tutor. He is said to have been the first Englishman who could properly read Aristotle and Galen in the original. Later he taught Greek at Oxford; also for a time he was physician to Henry VII, and had many illustrious patients. Linacre was greatly esteemed for his medical and literary works, as well as his excellent translations. He has been dubbed the "Restorer of Learning" in England. But to us his bringing the practice of medicine under the law seems most important.

Matteo Realdo Colombo or Realdus Columbus of Cremona (1510-1559) held the Chair of Anatomy at Padua. He published a famous book entitled, *DE RE ANATOMICA*, which is said to clearly foreshadow the correct scheme of the circulation. Yet since there is some question as to his having plagiarized, no more will be said of him.

John Caius or Kaye or Keys (1510-1573) who was born in Norwich, England, attended Cambridge and later studied medicine at Padua, whose medical school was unexcelled. He lived there with Vesalius. After returning to England where he practiced extensively with great success, he became court physician to Edward VI, Elizabeth and others of the royal family. His chief claim to our attention is that he was the first Englishman to write a descriptive work on a disease hitherto unknown, the Sweating Sickness. This terrible and rapidly fatal malady first invaded England in 1485, and recurred several times, always during the summer. The mortality was very great and its victims died within a few hours or less than one

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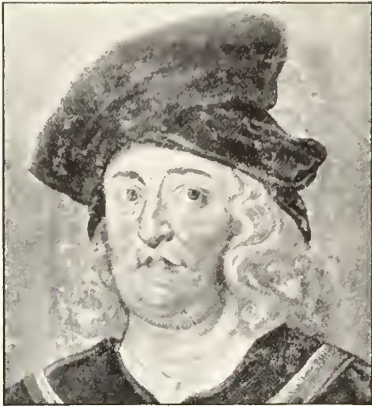
"Remember there are always two sides to every question. Get both sides. Then be truthful."

A good slogan . . . not just for a newspaper—for people, too. Because there'll always be two sides to every question: the side of those who vote one way, and those who vote another—the side of those who enjoy a temperate beverage like beer or ale, and of those who swear by nothing but cider.

And from where I sit, once you've got both sides—and faced them truthfully, you realize that these differences of opinion are a precious part of what we call Democracy—the right of the individual to vote as he believes, to speak his mind, to choose his own beverage of moderation, whether beer or cider.

Joe Marsh

day. Cains was a learned man and is said to have written many books ranging from medicine to history, and from plants to dogs.



Paracelsus (1493-1541)

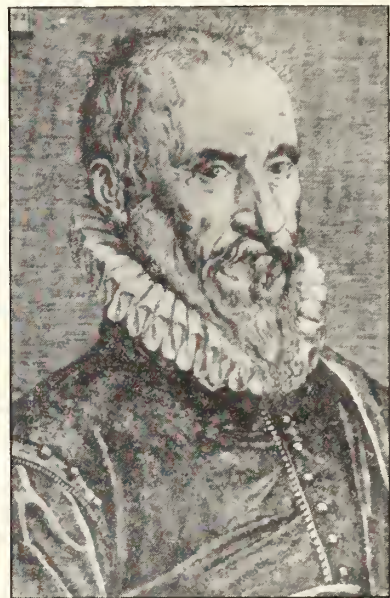
Paracelsus (1493-1541) though not properly esteemed for a long time has finally received the recognition due him. Even though an iconoclast, a brawler and a great braggart, yet he is entitled to our gratitude. For in ridiculing the trash that was in his day considered pharmacology and by making many and varied experiments with drugs he really is the father of pharmacology. Although born near Zurich in Switzerland he spent much of his life traveling. He journeyed through France, Germany, Italy, Sweden, Bohemia, Hungary, England and even Egypt. He studied in Montpellier, Bologna, Ferrara and of course Padua. He began his travels at the age of 23 and for 12 years was on his tours. He gave lectures at various universities and when only 33 years old was appointed Town Physician and Lecturer at Basel in Switzerland. This post he obtained through the great scholar Erasmus. William Osler has called Paracelsus the "Luther of Medicine." Our medical historian William F. Garrison writes of him as the "founder of chemical pharmacology and therapeutics." Of course he coined the name Paracelsus, but this was justifiable. His real name was Philippus Theophrastus Aureolus Bombastus von Hohenheim. Aside from his writings we should honor his memory, for he was the first European of his day who did not write in Latin. All his publications were in German, though later some were translated into Latin. He is said to have written over 300 medical works. Some of these were on diseases, others dealt with surgical matters and many with treatment. In his works he discussed all sorts of topics ranging from Miners Disease and Cretinism to Syphilis, Tuberculosis and Epilepsy. He was the first to use chemical substances in treatment and is said to have practiced asepsis. He seems far back in time medically, but he lived in the days of Henry VIII of England, and Francis I of France. He began life just after Christopher Columbus discovered America, and he died 20 years before Shakespeare's birth (1564). Although he may

not have been the mystic and humanitarian that Browning depicted, yet he undoubtedly was a dynamic and great character.

A name that is but a name to us is that of Bartolomeo Eustaccio or Eustachius (1520-1574). He taught medicine in Rome. His chief work was in anatomy and he is remembered as the discover of the Eustachian tube, the thoracic duct and the adrenal glands. His anatomical tablets which are said to be excellent and of a high quality, were published long after his death.

According to A. Castiglioni, Gabriele Fallopio or Fallopius (1523-1562) was "the most illustrious of the Italian anatomists of his day." He studied in Ferrara, Pisa and also Padua. He must have been very brave for he attacked the teachings of Galen. Some have placed him close to Vesalius, though he did not publish as great a work, nor did he stress the value of illustrations. He described the ear, the cerebral arteries, the clitoris, the extra-ocular muscles and the cranial nerves, etc., etc. The first edition of his *OPERA OMNIA* was published in Venice in 1584, next in Frankfurt and again in Venice in 1606. He was also a surgeon and was accused by some of being a vivisector. This was a common charge in those days. He did much to advance anatomy.

Although the great medical schools and the best known doctors were in Italy at this era, yet here and there in other lands there were a few men of distinction.



Ambroise Paré (1510-1590)

Ambroise Paré (1510-1590) was unquestionably the greatest surgeon of the Renaissance. He was born near Laval in Mayenne in France. He learned his art while a military surgeon and during a few years stay

in the Hotel Dieu in Paris. In his old age when 70 he wrote a famous book entitled, *JOURNEYS IN DIVERSE PLACES*. In this he relates the story of his travels, his surgical experiences and how he learned to care for the wounded. He was the first to give up pouring boiling oil into wounds and after amputations. Also Paré introduced the ligature, in place of the cautery which had been in use for over five centuries. Further he popularized the use of the truss for hernia. Garrison says that Paré had the courage to induce labor in cases of uterine hemorrhage. Dr. Howard A. Kelly gives him the credit for being the first to consider flies as transmitters of disease. He served as an army surgeon for 30 years, and later on he became surgeon to four kings of France successively. In addition to his writing on gunshot wounds, he discussed the treatment of fractures and dislocations. One volume he devoted entirely to obstetrics. He invented hemostats. Most of his life he was exposed to danger and barely escaped assassination at the time of St. Bartholomew's terrible Massacre (1572). Most of what he knew he gained by careful observation. He, unlike most of his contemporaries, knew neither Latin nor Greek. However, like Paracelsus and Vesalius he abhorred ignorance and superstition. He, by his own efforts, overcame many handicaps and rose from being a poor and obscure barber-surgeon to an illustrious place, and the greatest fame in all Europe.

It is extremely difficult to decide who among the great of this period should be included in a sketch such as this. A great many who were giants must necessarily be excluded. Nevertheless, there are several who cannot be omitted.

Michael Servetus (1511-1553) born near Lerida in Spain, was both a theologian and a physician. In 1553 most unfortunately, he published a book entitled, *CHRISTIANISM RESTITUTIO*. In this he gave his conception of the pulmonary circulation, thus antedating, though not equaling Harvey. Previously he had published other works which were also obnoxious to the Church. For as Victor Robinson says his views were of a "unitarian pantheistic nature." That is he did not believe in the Trinity; and he advocated tolerance to the Moors. It is said of him that "whatever subject he touched he illumined." Nevertheless after a trial of several months in Geneva he was convicted and sentenced by Calvin to be burned alive. Thus at the early age of 42 he became a martyr to the cause of science.

The name of Andreas Cesalpinus (1524-1603) means much to medical historians. He was a Professor of Medicine in Pisa and physician to Pope Clement VIII. He is regarded by Italians as a discoverer of the circulation before Harvey (1578-1657). Indeed he did seem to have the correct theory, but never proved it, as Harvey did. That is he understood the systemic and pulmonary circulations. In addition he was the first botanist, collecting plants from all over Europe.

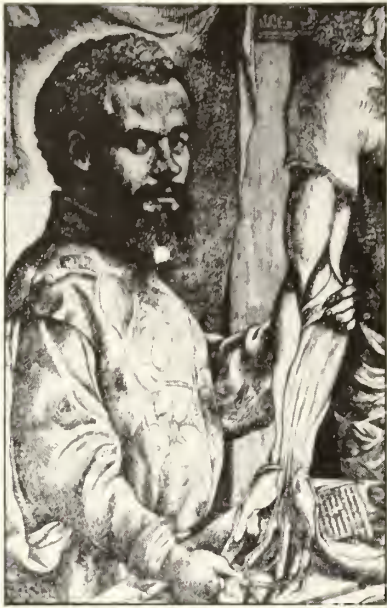
Girolamo Fracastoro (1484-1553) who is better known as Hieronymus Fracastorius, was born in Verona, Italy. He studied in Padua, and had as a fellow student, Copernicus (1473-1543) who became a famous astronomer. Fracastorius had an excellent education, and at first was professor of logic, and later a close student of the literature of the classics, as well as of science. He must have been very talented, for he is noted as a geographer, astronomer, physician, poet, physicist, geologist, musician, biologist and pathologist. In 1564 he published a treatise entitled, *DE CONTAGIONE*, in which it is claimed that he stated that infection was brought about by micro-organisms. In this he amplified ideas set down by Lucretius (98-55 B.C.) in his notable poem entitled, "De Rerum Natura" (on the nature of things). Further he studied intensively the plague, syphilis and typhus fever, and was the first to accurately describe this fever. But his chief claim to fame rests on the remarkable poem he wrote entitled, "Syphilis sive Morbus Gallicus," (Verona 1530). In this poem he traces the origin of syphilis. It relates the adventures of the handsome young shepherd Syphilus, who offended the god Apollo. His punishment was this disease. In the poem Fracastorius tells how it spread through Asia and then came to Italy from Gaul. He gives an account of the ravages of syphilis in its then malignant and epidemic form. For it is a well known fact that during this period it was extremely prevalent and very acute.* Let me quote from this poem:

"He first wore buboes dreadful to the sight,
First felt strange pains, and sleepless passed the night.
From him the malady received its name.
The neighboring shepherds catch'd the spreading flame." (Guthrie)

He discusses various treatments, especially with mercury and guiac and also writes of Divine aid. Any man who had such diversified talents and who has bestowed two books which are still highly rated, may easily be reckoned as one of the greatest of his day.

The limitations of time permit us to consider the life and work of only one more of these doctors of the Renaissance. This man has never been surpassed in his field. He is rightly called the Father of Anatomy. Andreas Vesalius (1514-1564) was the first to dissect the entire human body on a grand scale, classifying and systematizing it into the science of anatomy. Of course it is true that during the 15th and 16th centuries the great artists, Verocchio, Signorelli, Donatello, Leonardo da Vinci, Michaelangelo, Raphael, Albrecht Dürer, and others are known to have done some dissecting as a part of their studies in painting, wood-carving and sculpturing. But these studies were but incidental to their art, and lacked scope and plan.

* In 1509 in Venice, with a population of 300,000 there were over 11,000 public prostitutes. (Castiglioni, *A HISTORY OF MEDICINE*)

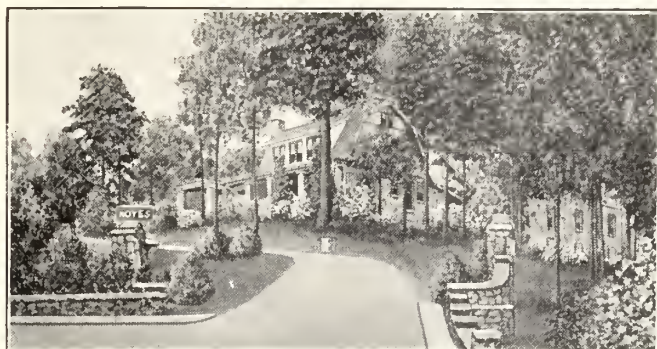


Andreas Vesalius (1514-1564)

It is also well known that anatomy had been taught at the school of Salerno in Italy for about three centuries. However, when dissections were first authorized by the illustrious Emperor Frederick II in 1231, they were permitted but once every five years. A hundred years had passed (1376) before the surgeons of Montpellier (France) were allowed to annually dissect the body of a criminal. Vesalius was born in Brussels in 1514. His father was apothecary to Charles V. He was well educated at Louvain, Belgium, and Leyden, Holland. At Louvain he learned not only Greek and Latin, but also Hebrew and Arabic. Thus he was able to translate from Galen and from Rhazes. Later he studied medicine in Paris. There only the barber demonstrator actually touched the cadaver. No attention was paid to the muscles, the joints or the bones. For a short time Vesalius was a military surgeon in Flanders and soon after he was lecturing in Italy in 1537. Next he visited Venice and from there went to Padua, where he received the degree of M.D. and also was appointed Professor of Anatomy. This university had been founded in 1222 and revived in 1260. In the 14th century it was greatly expanded and a "university of law and of artists" established, which included medicine. Since Padua lay outside the Papal States, it could and did escape the dictates of the Church. Not only Catholics had full privileges, but even Protestants and Jews. Thus it attracted to its faculty, men of learning and especially liberal teachers of medicine, since their safety was assured. Almost at once after becoming professor at the age of 22, Vesalius introduced dissection and discarded the giving of a reading from Galen. He changed the course in anatomy from four days to seven weeks. He dissected the human body instead of the pig. Gradually but

surely, he overthrew many of the incorrect anatomical teachings of Galen, which had been undisputed for 1400 years. His dissections and lectures attracted students from all over Europe, and at times 500 students crowded into the amphitheater. It is said that he made anatomy so interesting that his auditors tried to catch every word and that they watched him most intently as he dissected. For five years he labored unceasingly, and finally he was ready to give to the world his masterpiece, *DE FABRICA HUMANI CORPORIS*, which was published under his constant supervision at Basel in 1543.^o Sir George Newman has said that, "It began in a true sense the Renaissance of Medicine." The "De Fabrica" is a large volume of almost 700 pages, with many fine wood-cuts, which were made by the famous artist, J. S. Van Calcar, who was his friend and fellow countryman. Some claim that Calcar's famous teacher Titian contributed a few of the illustrations. As Guthrie writes, "it is no dead anatomy that is here represented. The subjects are full of life and expression, for the author sought to depict the body in action, and to teach physiology as well as anatomy." Sir William Osler considered it the greatest medical book ever written from which modern medicine starts. Naturally there was much opposition when it appeared. Some of the most eminent professors would not accept his discoveries. Men in the top rank, especially Sylvius of Paris and Eustachius of Rome violently attacked him. One opponent even went so far as to say that if Vesalius were correct, then man's body in the 16th century had greatly changed from what it had been in Galen's time, for Vesalius had dared to oppose Galen in many things. He even stated that the heart did not have an opening in the interventricular septum as had been believed for centuries. Without in any way belittling the skill of Vesalius it should be conceded that his timing was most fortunate. For 12 years before the "Fabrica" was published, Albrecht Dürer in Nuremberg had printed his great treatise on "Human Proportions." In this, for the first time "shades and shadows were represented by means of cross-hatching." A year prior to the appearance of his "Fabrica," Vesalius had written a small volume which was an "Epitome." Although Vesalius was energetic and most industrious while working on his books, yet when he had done his work he could not stand the bitter criticism and the ceaseless envy and vituperation. So to escape all unpleasantness and perhaps even danger, he forsook Italy, and journeyed to Spain. While there, as physician to the Emperor Charles V, he attended court much of the time, soon married, practiced medicine and surgery and became rich. But no longer did he dissect. He made no contributions to science. However, about this time (1561) Fallopius, his former pupil published a volume of great merit entitled,

^o Oddly enough in that same year, Copernicus had published his great work entitled, *DE REVOLUTIONIBUS ORBIUM COELESTIUM*, which was the beginning of modern astronomy.



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ANATOMICAL OBSERVATIONS; and it happened that a volume reached Vesalius. He was greatly surprised, perhaps even jealous, and he decided to resume his anatomical investigations, but fate willed otherwise. For soon after this a nobleman whom he was attending died from an obscure illness and Vesalius performed the autopsy. Most unfortunately it was noticed by him and those observing that the heart continued to beat after its exposure. This was a most serious matter, particularly in Spain, and at this time when the Inquisition had control. Further Vesalius was already in bad favor with the Church. So he hurriedly left Spain, perhaps voluntarily, or more likely on orders from the Pope. He made a pilgrimage to the Holy Land. After leaving Palestine, Vesalius visited the island of Cyprus, and while there he heard of the untimely death of his brilliant successor, the youthful Fallopius. Very soon after this Vesalius was invited to become once more Professor of Anatomy at Padua. But this was not to be; for on the homeward voyage in the Ionian Sea, the ship was wrecked, and although Vesalius reached the island of Zante, he died soon after, most probably from Typhoid Fever. In all likelihood had he lived, he would have won even greater fame, for he was only 50 years old, and at Padua would have had almost unlimited opportunities. His followers were men of considerable ability, but stars of lesser magnitude.

And so we have come to the end of this talk on the Renaissance and some of its doctors. Many have been omitted who deserved inclusion, and scant attention has been paid to some worthy of a lengthier sketch, but at least what has been said may faintly show what a marvelous age that period was, and how there appeared on this earthly stage, in several countries,

men who had courage, mentality and vision. We of today are much better off because of their having lived, and science has been tremendously enriched by their labor and wisdom.

REFERENCES

1. Bashford, H. H.; *THE HARLEY STREET CAL-
ENDAR*; Houghton Mifflin Co.; Boston and New
York; 1929.
2. Castiglioni, Arturo, M.D.; translated from the
Italian by E. B. Krumhaar, M. D., Ph.D.; *A
HISTORY OF MEDICINE*; Alfred A. Knopf;
New York, N. Y.; 1941.
3. Garrison, Fielding H., A.M., M.D., *HISTORY
OF MEDICINE*; Edition IV; W. B. Saunders &
Co., Philadelphia and London; 1929.
4. Guthrie, Douglas, M.D., F.R.C.S., Ed., F.R.S.E.;
A HISTORY OF MEDICINE; J. P. Lippincott
Company; Philadelphia; 1946.
5. Major, Ralph H., M.D.; *CLASSIC DESCRIP-
TIONS OF DISEASE*; Charles C. Thomas Co.;
Springfield, Ill.; 1945.
6. Paré, Ambroise; translated by Stephen Paget;
JOURNEYS IN DIVERSE PLACES; The Har-
vard Classics, Vol. XXXVIII, pages 9-61; P. F.
Collier; New York, N. Y.; 1910.
7. Robinson, Victor, M.D.; *THE STORY OF
MEDICINE*; The New Home Library; New
York, N. Y.; 1943.
8. Symonds, John Addington; *RENAISSANCE IN
ITALY*; Volume I; The Modern Library; New
York, N. Y.; 1935.
9. Wells, H. G.; *THE OUTLINE OF HISTORY*;
Edition III; The Macmillan Co.; New York,
N. Y.; 1921.

ABSTRACTS

**Brescia, M. A. and Tartaglione, E. F.: Prenatal
Diphtheria Immunization; Arch. of Ped.; 65: 633-
639; December 1948.**

In a previous communication Dr. Brescia reported on the status of diphtheria immunity in mothers and their infants and concluded that all pregnant women should be Schick tested as a part of their prenatal care, and if found Schick positive, they should be actively immunized. He further recommended that infants born of immune (Schick negative) mothers should be immunized at six months of age. These recommendations were made in order to increase the immunity of adult population and to insure the newborn immunity during the first six months of life.

In the present study the authors immunized nineteen Schick positive pregnant women with alum-precipitated toxoid in five doses, beginning with 0.1 cc., repeated in one week by 0.25 cc. and in two weeks by .5 cc. and then 1.0 cc. for two doses a month

apart. Reactions occurred with only the first two injections. The mothers and infants were all converted to Schick negative.

Six Schick positive pregnant women with a definite history of diphtheria immunization during childhood were given a single "booster" injection of 0.25 cc. These and their newborn infants were all converted to Schick negative.

The authors restate the above recommendations and further recommend that infants born of Schick positive mothers should be immunized at one month of age, and that if the Schick testing is burdensome, then the most good can be obtained by routinely administering a "booster dose" of diphtheria toxoid.

**Hunt, C. J.: Early Diagnosis and Roentgen
Manifestations of Obstruction of Small Bowel;
Arch. Surg.; 57: 460-469; October 1918.**

The three chief features of small bowel obstruction

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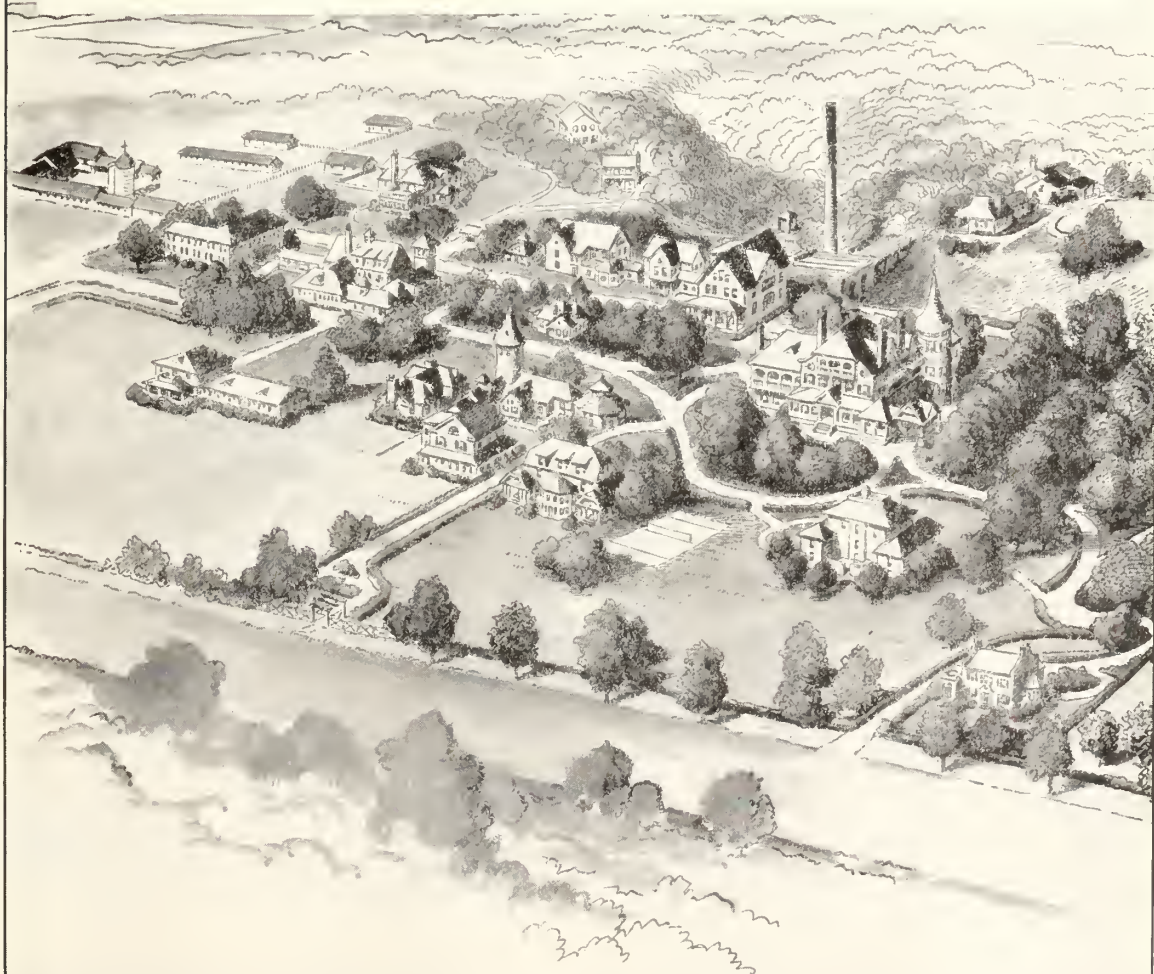
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L I T E R A T U R E O N R E Q U E S T

are pain, peristalsis and borborygmus. The pain is in no way related to any other type of abdominal pain. It is generalized, diffuse, and not associated with tenderness or muscle spasm, and is not continuous but spasmodic in character. Peristalsis is sometimes visible in early obstruction. It increases in prominence as the pain progresses and subsides with the cessation of pain. It is significant and diagnostic if present, but not nearly as frequent as the colicky pain and borborygmus. Borborygmi are synchronous with intestinal colic and visible peristalsis. The passage of gas or the evacuation of the bowels may occur. It is present often in complete bowel obstruction and should not give a false sense of security as to bowel patency.

The roentgenogram is the only means by which one can make an early diagnosis of small bowel obstruction and can determine accurately the type of obstruction present. In simple obstruction the proximal bowel distends, coil by coil, and gradually assumes a transverse relationship to the long axis of the body, and the valvulae conniventes can be seen. Here intubation may first be done and operation as an elective procedure later if necessary. However, if the bowel assumes no definite pattern, is found distended in an irregular manner and is darker than in the previous type, the obstruction is one of a strangulated type and immediate operation is imperative.

The author feels the Miller-Abbott tube is beneficial in selected cases of intestinal obstruction.

Pickering, G. W.: Lumbar Puncture Headache; Brain; 71 Part III: 274-280; 1948.

The author states that after puncture of the spinal theca it is not uncommon for a characteristic headache to develop. The pain may be generalized over the calvarium but is often especially severe at the back of the head and may spread into the neck, shoulders or back. Neck rigidity is common. The invariable feature which distinguishes this headache from all others is its reaction to change of posture, its very striking exacerbation when the patient sits up, and its relief when the patient lies down. It has been shown by previous workers that the headache is due to a leakage of cerebrospinal fluid from the hole made by the needle.

The author in a study of 11 cases with lumbar puncture headache finds the cerebrospinal fluid pressure to be atmospheric or only slightly above, and that the injection of 30 to 50 cc of saline is sufficient to restore the pressure to the lower limits of normal and to abolish the headache. The headache usually lasts for 24 hours and is invariably made worse by sitting up. Shaking the head increases the headache. Here the meninges are held responsible. Compression of the jugular vein increased the severity of the headache while compression of the carotid artery decreased it. The headache throbbed with the pulse beat in the majority of cases.

The author concludes that lumbar puncture headache is ascribed to caudad displacement of the base and posterior parts of the brain with tension on the anchoring structures, particularly the tissues around the large arteries at the base.

Manfredi, D. H.: Chronic Appendicitis and Mesenteric Adenitis in Children; Arch. Ped.; 65: 591-595; November 1948.

Cases of chronic appendicitis and mesenteric lymphadenitis of non-tuberculous origin present a commonplace problem in the field of children's surgery. 480 cases of chronic appendicitis and mesenteric adenitis have been analyzed by the author. He surmises that there may be a relationship between the lymphatics of the appendix and the lymphatics of the mesentery due to the excellent results obtained in these two diseases following appendectomy. Experiments have shown that lamp black from the intestines is frequently found in the mesenteric nodes.

The prepuberty age group seems to be mostly involved probably due to the maximum growth of mesenteric lymph nodes at that period. The mesenteric glands are divided into three groups, juxta-intestinal group which is always and early involved, intermediate group and terminal group.

The clinical picture in the two diseases is similar and at times indistinguishable. Once a diagnosis of chronic appendicitis or mesenteric adenitis is made appendectomy is the treatment of choice. Post-operatively these patients improve both in their general health and in their abdominal complaints. Recurrences are rare following appendectomy but numerous in those treated conservatively. With appendectomy the danger of overlooking an acutely inflamed appendix is avoided.

Amendola, F. H.: The Management of Massive Gastroduodenal Hemorrhage; Ann. Surg., 129: 47-56, January 1949.

The author states that the term massive hemorrhage should be applied only to an acute, rapid loss of blood producing hemorrhagic shock. Gastric, duodenal, and anastomatic ulcer are responsible for approximately 85% of the gross hemorrhages from the upper digestive tract.

A series of 120 cases of massive gastroduodenal hemorrhage is presented by the author with the following plan of management: (1) immediate active treatment for shock, (2) only water or cracked ice by mouth, (3) blood replacement begun at once, (4) blood drawn for hematocrit, prothrombin, urea, typing and blood counts, (5) continuous transfusions until systolic pressure over 90 and pulse under 130, (6) rapid history and physical to determine source of bleeding, (7) barium ingestion and roentgen ex-



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amination when patient is no longer in shock if diagnosis in doubt, (8) indwelling tube placed in the stomach for continuous suction if esophageal varices are ruled out, (9) opiates, barbiturates, or both to control restlessness, (10) bodily requirements met by intravenous infusions—when bleeding stops patient is placed on progressive ulcer diet.

Indications for operations in chronic ulcer are (1) continuous bleeding in older patients for 24 hours, (2) continuous bleeding in younger patients for 48 hours, (3) recurrence of massive bleeding in the older patient, (4) massive bleeding superimposed on pyloric obstruction, (5) simultaneous hemorrhage and perforation.

The author concludes that the treatment of bleeding peptic ulcer is the joint responsibility of internist and surgeon.

Kerr, Jack G.: Polyposis of the Colon in Children; The Amer. J. of Surg.; 76; 667-671; December, 1948.

The examination of 349 children presenting bowel symptoms disclosed 100 to have one or more polyps of

the colon. The painless passage of blood-tinged mucus was the single symptom common to this group. Other symptoms were in the order of their frequency: protrusion of the polyp in 28%; diarrhea in 19% and abdominal cramps in 18%.

Bleeding from a polyp usually occurs intermittently and weeks may intervene between episodes. Self amputation occurs frequently in children and the polyp is extruded through the anus. Protrusion of the polyp from the anus does not determine accurately the height of its attachment. True diarrhea is not uncommon and of doubtful significance. Abdominal cramps varied in intensity with the size of the polyp and its location.

Repeated roentgen ray studies should be made when a polyp is suspected and not visualized through a proctoscope 25 cm. in length.

The possibility of malignant degeneration and of other serious complications including anemia, obstruction and intus-susception constitutes a definite indication for removal of the lesions.

Removal may be accomplished by fulguration if the lesion is situated within 25 cm. of the anal outlet and by colotomy if it is above that level.

PUBLIC HEALTH NEWS

DR. HARRY WILSON MADE DIRECTOR OF LABORATORIES

Dr. Harry F. Wilson, who has been acting director of the Division of Laboratories since Dr. H. M. Smith retired in July 1947, was appointed director by the Executive Committee at its meeting on February 17. The appointment was immediately effective. He is also serving as acting director of the Division of Industrial Health, of which he had been director since 1936, except for five years spent in military service.

Dr. Wilson began his service with the State Board of Health in 1928 as county health officer for Horry County. In 1932 he was assigned to Beaufort County, and in 1934 to Dillon County, where he served until 1936 when he was appointed director of the Division of Industrial Health.

CHANGE IN POSTAL REGULATIONS

The attention of all county health departments is called to a change of postal regulations effective January 1, 1949. The rates for mailing bacteriological and blood samples to the Division of Laboratories has been increased.

Please check with your local postmaster concerning these new rates. This will avoid delay in the delivery of specimens to the laboratory which might be caused by the postal department holding them for inadequate postage.

S. C. MENTAL AND SOCIAL HYGIENE SOCIETY HOLDS ANNUAL MEETING

The South Carolina Mental and Social Hygiene Society went on record at its annual meeting in Columbia on February 19 as approving the proposed

marriage bill awaiting Senate action, with the inclusion of an amendment stating that venereal disease must be in the infectious stage. The measure requires a three-day waiting period between application for a license and obtaining it; and a health examination for venereal disease.

The meeting, which was held at the Jefferson Hotel and presided over by the Society's president, Dr. Hilla Sheriff, had a large attendance from over the State. Among the highlights of the program was a luncheon session at which Governor J. Strom Thurmond presented Dr. John R. Heller, a native of Fair Play, S. C., and director of the National Cancer Institute of the U. S. Public Health Service, with an honorary life membership in the American Social Hygiene Association. Dr. Heller was selected for the honor by the Association's Committee on Awards. Governor Thurmond also presented Dr. Heller with an official flag of the State of South Carolina.

At the luncheon meeting, Dr. R. A. Vonderlehr, medical director in charge of the Communicable Disease Center, U. S. Public Health Service, Atlanta, Ga., addressed the group on the topic, "The Venereal Disease Control Program—Then and Now."

Doctor Vonderlehr quoted statistics, and pointed out how much had been accomplished in the control of syphilis and gonorrhea in the past few years.

"Very marked progress" is evident, he said, in the treatment of venereal disease.

He pointed out that three fourths of the states now have premarital laws.

"Clinics today number over 3,000," Doctor Vonderlehr said. "Therapy has advanced so far that it looks as if there will be a greater need for clinics than for rapid treatment wards."

That responsible citizens must take a look at the

community's social hygiene needs was stressed by speakers to the meeting. Basic needs in a community program are:

Family life education, with home, school, church and community responsible; community facilities for maintaining wholesome conditions as a curb on promiscuous sex behaviour; intelligent support for public health and medical measures designed to find and treat VD and public education about venereal disease.

South Carolina's responsibility in promoting a program for a stronger family life was outlined by Dr. Ben F. Wyman, State Health Officer; Dr. James W. Jackson, pastor of the First Presbyterian Church of Columbia; and Dr. A. C. Flora, superintendent of the Columbia City Schools.

Dr. Wyman said that last year 7,511 cases of syphilis and 9,824 of gonorrhea were reported, but called attention to the fact that few were reported by practitioners, consequently the figures were not always accurate.

Pointing out that one blood test is evidence but not the final diagnosis for venereal disease, he said that of 6,053 cases listed last year as VD at the rapid treatment hospital in Florence, 384 who had had similar tests were found to have no VD.

"We must realize that disease is a community affair," Dr. Jackson said. "To strengthen the community in which the family lives we must interest ourselves in the community, not escape from it; we must benefit from the education a community gives us; and we should plan ahead to improve the community."

"The teaching personnel of the city schools is the basic thing in the whole school program for the strengthening of young people," Dr. Flora told the group. "A healthy atmosphere; a well-rounded environment, which includes the spiritual; and well-developed program of activities are other important aspects.

"If we are going to be concerned with our young

people, we must be concerned with the total environment. And we can't have a beautiful environment around our city and have a rotten core inside."

During a discussion on sex hygiene education for young people, Dr. Flora said, "I am very much in favor of a school doing all it can regarding sex education. But the school is only a segment of the total picture, and we can only do what the home, church and community permit us to do.

"If I were labelling a course, however, I would take out the word sex. That word is used to get the crowd, and we don't want to talk about just that, but about healthy human beings."

Miss Jean Pinney, editor of the Journal of Social Hygiene, gave an outline of the Association's work here and abroad.

She talked of the closely knit work being done with the United Nations at Lake Success, and stressed the need throughout the country for up-to-date material on social hygiene.

The health and moral progress of the United States Navy was discussed by Commander W. J. Dougherty (MC) of Silver Springs, Md. The speaker outlined the work of the Navy toward keeping environment on a high plane. He urged "know your community and the influences that are detrimental to the man in service."

He told how the Navy is instructed in the dangers of VD, but said that the decision to avoid exposure rests with the man himself. "The preservation of the future family stems from the present family. It is the influences of the home, the school, the church and the community which are important."

Commander Dougherty said the Navy is faced with the problem of controlling the environment. Hotels, bars, etc., are named infrequently, for an average of 85 percent of the contacts are commercial pick-ups rather than professionals.

"VD is on the downward trend in the Navy," he said.

The following members of the Association have paid the A. M. A. Assessment of \$25.00 during the past month (Feb. 20 - March 20.)

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Howell, J. R.
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ANDERSON

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Wilson, Lester A.

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 ASHEVILLE, N. C.
 Baldwin, Marie

NEWS ITEMS

Dr. Coyt Ham has opened an office at 1419 Bull Street, Columbia, and is limiting his work to neuro-psychiatry.

Dr. Clay W. Evatt has announced the association of Dr. David R. Stack in the practice of ophthalmology, otolaryngology and maxillofacial surgery, at 91 Rutledge Avenue, Charleston.

Dr. J. Warren White of Greenville has been elected

a member of the committee on certification examinations of the American Board of Orthopedic Surgery.

Dr. J. Decherd Guess of Greenville conducted the Part I examination of the American Board of Gynecology and Obstetrics for this area at the American Board of Gynecology and Obstetrics for this area at the February examination date.

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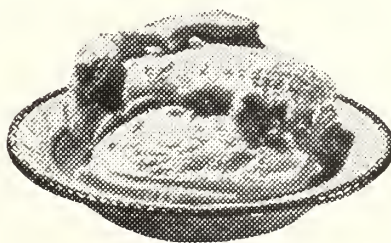
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Drug Administration is making seizure of Syrup of Urethane. This is a cough syrup manufactured by Marvin R. Thompson, Inc., Stamford, Conn. Physicians, pharmacists, and consumers are warned that the administration of Urethane in the quantity recommended on the label may cause a dangerous lowering of the white blood cell count. This leaves the patient more liable to infection from disease germs. Individuals suffering from coughs are likely to have accompanying infections.

The South Atlantic Association of Obstetricians and Gynecologists announces the establishment of "The Foundation Prize." Authors of papers on Obstetrical or Gynecological subjects desiring to compete for the prize may obtain information from Dr. E. D. Colvin, Secretary-Treasurer, 1259 Clifton Road, N. E., Atlanta, Ga.

INTERNATIONAL CONGRESS ON RHEUMATIC DISEASES

The first International Congress on Rheumatic Diseases ever held in the United States will take place at the Waldorf Astoria in New York City May 30 to June 3, 1949 inclusive. This seventh International Congress is sponsored by the International League against Rheumatism. The host is the American Rheumatism Association in cooperation with the New York Rheumatism Association.

Seven (five morning and two afternoon) scientific sessions are planned. Also five one-hour round table conferences on various clinical topics will be held under the leadership of authorities in the respective fields. Short clinics, papers and reports will be given concurrently at four or five New York hospitals during three afternoons. Evening entertainment will be provided. The registration fee is \$10.00.

Instantaneous translations of the scientific papers will be made by means of the I. B. M. wireless system similar to that used at the sessions of the United Nations. The official languages of the Congress will be English, French and Spanish.

The Congress has the official sanction of the United States Department of State which will cooperate in the issuance of official invitations. This is an open meeting. Members of the International, the European, and the Pan American Leagues against Rheumatism as well as the Canadian Rheumatism Association, British Empire Rheumatism Council, the Heberden Society of London, and the ten state or city Rheumatism Societies affiliated with the American Rheumatism Association are especially invited.

The Seventeenth Annual Assembly of The South-eastern Surgical Congress will be held in Biloxi, Mississippi, The Buena Vista Hotel, May 23, 24, 25, 26, 1949.

There will be forty-three papers presented by distinguished surgeons from the South and throughout the country. This is a very comprehensive program and the medical profession would do well to take advantage of this opportunity to hear these men.

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The Purpuric State

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Medical College of the State of South Carolina,
Charleston, S. C.

To both the physician and the patient, the sudden development of hemorrhagic purpura is indeed a spectacular event. The demand for attention on the part of the patient is usually urgent, and it is equally important for the physician to make an accurate mechanistic diagnosis in order that prompt and correct therapeutic measures be instituted.

In the present study simple purpura is not considered. I am concerned only with the thrombocytopoenic type, which may result from any one of a number of known toxic agents or which may be of unknown origin; it may occur alone or in combination with other blood dyscrasias; it may result from peripheral platelet destruction or from central bone marrow disturbance. It is highly important to determine in just which group any given case belongs, as the management of one type differs considerably from that of another type of the disorder.

In a review of hemorrhagic purpura published in 1936 Patek¹ observes that "thrombocytopoenic purpura indistinguishable from essential thrombocytopoenia has been reported as following the administration of the arsphenamines, quinine, 'sedormid', 'nirvanol', milk and other foods, and possibly from bacterial sensitivity following certain acute infections." Since that time cases have been reported as following the administration of certain sulfonamides,² sodium salicylate,³ quinidine,⁴ following gold therapy in arthritis, and following scarlatinal infection.⁵ The study of several of these secondary types of thrombocytopoenia suggests that in certain of them, perhaps in most, the condition arises from a destruction of the platelets in the peripheral circulation; the promptness with which recovery occurs in many of them and the lack of evident damage to the granulocytic and erythrocytic series makes it unlikely that there has been central marrow disturbance.

Illustrative of this type of secondary purpura are the following cases:

Case 1: An 81-year-old white woman with moderate arteriosclerosis suffered from occasional recurrent attacks of paroxysmal tachycardia. These had been controlled on several previous occasions with quinidine sulphate. Two of these attacks occurred within a period of a few days in May 1946 and quinidine was begun. After taking 36 grains of quinidine in the course of 4 days the patient began to bleed from the mouth and several large submucosal hematomas quickly appeared. Within a few hours a profuse purpuric eruption over the entire body was noted. The platelet count was 18,000, the bleeding time over 50 minutes. On admission to the hospital the hemoglobin was 11 Gms., red cell count 3.94 million, both consistent with the degree of blood loss experienced by the patient. White cell and differential counts were not remarkable. X-ray treatment was begun, the patient receiving a total of 600 Roentgen units, three daily doses of 200 R. each. A transfusion of fresh citrated whole blood was given daily for the first 6 days. Within 48 hours the bleeding was controlled, although it was not until 3 days later that the platelet count showed any appreciable rise. The patient made a complete recovery and there has since been no recurrence of purpura; no further quinidine has been given and other methods have been used to control the tachycardia.

Case 2: Another similar type of case is the story of a 30-year-old white woman, under treatment for latent syphilis with bismarsen, who began to bleed from the gums and developed a purpuric eruption 3 hours after her 23rd injection. When first seen 2 days later there was profuse purpura, subconjunctival hemorrhage, and bleeding from the gums had persisted. The spleen was not enlarged. Typical laboratory findings of thrombocytopoenic purpura were present, with a platelet count of 36,000, bleeding time 20 minutes, normal coagulation time but very little retraction of the clot. The hemoglobin was 77%, red cell count 4.85 million, white cell count normal. With no specific treatment other than supportive and ascorbic acid by mouth the

bleeding ceased, purpura cleared, and the platelet count and bleeding time returned to normal 6 days after onset. No transfusion was thought necessary and there has been no recurrence since that time.

Case 3: Another case previously reported by F. B. McCarthy and myself⁶ was that of a 49-year-old white man, under treatment for Syphilitic heart disease, who was given 32 injections of Bismuth and 21 injections of Neoarsphenamine, each 0.3 Gms. Immediately after the last injection bleeding from the gums appeared, shock occurred and within a few hours a profuse purpuric eruption was present. No platelets were to be found on the blood smear, coagulation time was 5 minutes and there was no retraction of the clot. The bleeding time 1 day later, after the patient had begun to improve, was 10 minutes. No specific treatment was given and the patient made a complete and uneventful recovery.

It was concluded in this study that the thrombocytopenic type of reaction following the arsphenamines was of an "anaphylactoid" nature, all of the cases reviewed having occurred only after considerable treatment with a large number of injections of arsenicals and it was thought that probably a specific sensitivity toward the arsphenamines gradually took place. In both of these cases and in the case following quinidine there was no evident damage to the erythrocytes or to the granulocytic series; the suddenness with which symptoms came on suggests a widespread destruction of platelets in the peripheral circulation and the speed with which recovery took place is definite evidence that bone marrow function remained normal. In retrospect I now believe that the radiation treatment given to Case 1 (following quinidine) was superfluous and had nothing to do with her quick recovery. In none of these cases was there any suggestion of a splenic factor concerned in the development of the thrombocytopenia and in this type splenectomy is never to be considered.

Secondary thrombocytopenia may also occur in conditions which primarily involve the bone marrow. This type of reaction is seen in the purpura which sometimes accompanies the Leukemic state and in the purpura of aplastic anemia which follows bone marrow damage by the arsphenamines. It is a question as to whether or not this is the type of reaction which occurs as a result of gold therapy. However, as an illustration the following case is cited:

Case 4: A 52-year-old white woman who had suffered for several years from a crippling rheumatoid Arthritis was started on gold therapy in Nov. 1942. During the following 6 months she received 25 injections for a total of 1.04 Gms. of the preparation (Solangol B Oleosum). After an interim of 6 months she was begun again on another series in Nov. 1943, and 4 days after the 8th injection in this course (total 165 mg.) a profuse purpuric eruption suddenly appeared. The platelet count was 35,000. A few days after onset the spleen was found to be slightly en-

larged. The patient received 10 transfusions in the first 2 weeks of her hospital stay. Radiation treatment was begun and over the course of 2½ months she was given a total of 3350 R. The platelet count remained below 100,000 for the first 2 weeks, then ranged between 100,000 and 200,000, dropping to 92,000 on 2 occasions but rising promptly after further radiation. The purpuric eruption did not reappear after the platelet count rose and free bleeding was not present at any time. In the study of the bone marrow of this patient taken several weeks after onset, megakaryocytes were practically absent from the smear, and the granulopoietic tissue showed some immaturity, thought to be due to a toxic process. The rather long continued thrombocytopenia suggests that there was more than a simple peripheral destruction of platelets, and the paucity of megakaryocytes some weeks later is in accord with the view that there was central bone marrow damage in this case. The subsequent course of the patient, however, shows that this damage was not irreversible and it is probable that repeated transfusions were the means of keeping her alive until spontaneous recuperation and later recovery took place. Since this episode there has been no recurrence of purpura or thrombocytopenia in this patient.

The clinical picture encountered in primary or essential thrombocytopenia is quite different from that of the cases cited above. While there is considerable disagreement as to many details all writers agree that certainly in cases of idiopathic thrombocytopenia the splenic factor is paramount. The beneficial effects of splenectomy, with complete relief of symptoms and return of the platelet count to more nearly normal levels, has long been observed. Recently it has been demonstrated^{7, 8} that acetone extracts of splenic tissue from cases of essential thrombocytopenia have a transient but significant depression on the platelet counts of experimental animals. In this work no changes in the marrow or in the megakaryocytes have been noted. These observations all point to the effect of hypersplenism in the production of thrombocytopenia, and when this mechanism is involved splenectomy is the indicated method of treatment.

Illustrating this type of reaction, the following cases are presented:

Case 5: A 5-year-old white girl was first seen in May 1942 because of slight bleeding from the gums, a few purpuric spots, and large non-traumatic ecchymoses over the body. The spleen was not felt on examination. The bleeding time was 10 minutes, the platelet count 105,000, which later fell to 33,000. With transfusion and radiation the symptoms were well controlled but the tendency to easy bruising persisted and nosebleed occurred at infrequent intervals. In June 1943 splenectomy was performed and the patient had an uneventful recovery from operation. There has been no recurrence in the past 4½ years except for nosebleed on one occasion, when the platelet count was normal.

Case 6: A 20-year-old white woman developed purpura one month after the birth of her first child in Sept. 1942. Symptoms included nosebleed at frequent intervals, slight menorrhagia, a tendency to bruise rather easily and a profuse purpuric eruption. The spleen was not felt on examination. Laboratory findings were typical of thrombocytopoenic purpura with a platelet count of 38,000 and bleeding time of 20 minutes. Splenectomy was carried out on Feb. 8, 1944, the spleen weighing 135 Gms. and showing no abnormality on pathologic examination.

Symptoms and laboratory findings quickly returned to normal, but there was some recurrence of purpura 7 weeks later. Studies at this time showed a low platelet count but the bleeding time was normal. Treatment by radiation was given (1100 R.) as it was felt that the thorough examination made at exploration allowed little likelihood of an accessory spleen being present. Under this therapy the patient became symptom-free, the platelet count rose to normal levels and the bleeding time remained normal. On reexamination 2 years later there had been no recurrence.

These 2 cases are quite similar in most respects. In both the symptoms were rather mild and in neither did extensive bleeding occur, nor was there any pronounced fall in the levels of the hemoglobin and red cell counts. In both patients the duration of symptoms was a little over a year before operative treatment and both were completely relieved by splenectomy. In neither of these patients was a bone marrow study made but the subsequent course suggests that hypersplenism was the essential factor in their thrombocytopoenia. It seems quite certain that if any depression of megakaryocytes had been present before operation the changes were not irreversible and were completely relieved after splenectomy.

Although diagnosed as idiopathic thrombocytopoenia, the following cases are quite different from those immediately preceeding:

Case 7: A 25-year-old colored woman was admitted to the hospital with a story of the rather sudden onset of bleeding from the mouth 4 days before. At first she had been suspected of hemoptysis and sent to a Tuberculosis Sanatorium where the nature of her bleeding was established. There was also a story of some menorrhagia during the 2 or 3 months before hospitalization, but the patient denied that this had existed previously. On physical examination extreme pallor was noted and there was constant bleeding from the gums with large submucosal hematomas in the mouth. A few purpuric spots were seen over the chest wall but the skin was quite dark and purpura was recognized only with some difficulty. The abdomen was moderately distended and the spleen was not felt. The original platelet count was 18,000, the bleeding time more than 30 minutes. The blood showed a pronounced anemia with a hemoglobin of 4.25 Gms. and a red cell count of 1.75 million. Many nucleated red cells were seen in the smear. The patient ex-

perienced almost continuous bleeding from the mouth and often from the vagina as well. 14 blood transfusions, a total of 7000 cc. were given without effect on the bleeding time, and although the hemoglobin rose to 10 Gms. and the red cell count to 3.02 million on one occasion, persistent bleeding soon brought this back to its original level. Radiation therapy (total 1200 R.) was also used without benefit. The consulting surgeons felt that the risk of operative treatment was too great for splenectomy to be undertaken and the patient could not be gotten into a condition for this to be done. Unfortunately her mother removed her from the hospital against advice but brought her back a day later where she died, probably from cerebral and intraperitoneal hemorrhage. Permission for autopsy was not obtained but the patient's physician removed her spleen and brought it to us for examination. This proved to be histologically normal but it was enlarged and weighed 215 Gms.

Case 8: A 49-year-old white man entered the Roper Hospital in Dec. 1946 with a story of a febrile episode 3 months previously, complicated by hematemesis and probable purpura. The true nature of his illness had not been recognized at its onset and he had been treated for peptic ulcer, however without improvement. To one examiner he stated that he had had a recurrent skin eruption for 5 years, to another for only 3 months, but during this latter period he had had a daily rise in temperature, nosebleed, weakness and dyspnea on exertion. Physical examination showed profuse purpura, extreme pallor, generalized lymphadenopathy, organized exudates and evidences of previous bleeding in both ocular fundi, and an enlarged spleen. The platelet count was 23,000, bleeding time 2 minutes. On admission to the hospital the hemoglobin was 3 Gms., red cell count 3.4 million, reticulocytes 18%, volume of packed cells 19%, M.C.V. 146 and V.I. 1.56. Although there was a history of both malaria and hookworm infestation, examinations for these parasites were negative. The study of the bone marrow, obtained by sternal aspiration, showed markedly hyperactive erythropoiesis, with nucleated cells and megaloblasts dominating the picture. The platelets were practically absent from the smear and the megakaryocytes extremely scarce, those present showing poor maturation.

The patient lived only 6 days after admission to the hospital. Fever was present each day, always to 101 and on 1 occasion to 104. Agglutination tests and several blood cultures were negative. Splenectomy was planned and he received 3 blood transfusions of 500 cc. each. Shortly after the last transfusion the patient complained of severe headache and abdominal pain and died rather suddenly a few hours later. The cause of death was ascertained by autopsy to be due to an extensive intramyocardial hemorrhage involving the right auricle and ventricle. Hemorrhage and encephalomalacia of the right cerebellar hemisphere, with some subarachnoid hemorrhage, were also found. The spleen was enlarged, weighed 400 Gm., but was histo-

logically normal. The liver was likewise enlarged (2000 Gms.) and all of the internal organs showed many focal hemorrhages.

Until we know something about the cause of idiopathic thrombocytopenia and a good deal more about the hematologic mechanisms involved, it is difficult to explain all of the observed facts. The clinical picture presented by the last two patients (Cases 7 & 8) is so different from that of the first two cases of this group that one wonders if we are dealing with the same disease. However, in all of them the factor of hypersplenism was present and on this basis they are all to be considered as cases of essential thrombocytopenia. If we assume that there may be variations in the intensity of this factor and in individual susceptibility to its effect, the differences in the case histories are less striking. In the first two patients hypersplenism was apparently of a mild degree of intensity and the blood loss experienced by neither was enough to place any undue strain on the erythropoietic system. In the two fatal cases the situation was reversed, perhaps from a more intense splenic activity or perhaps from a longer duration of its effect, and both patients died from the bleeding disorder before adequate therapy could be employed. The importance of the time element becomes evident. If successful treatment is to be carried out, splenectomy must be performed before the disorder has proved too much of a drain on the blood-forming systems. And certainly in patients who cannot be adequately followed, once the diagnosis is established, this should mean early operative treatment.

In regard to the effect of hypersplenism on the bone marrow there is considerable disagreement. Wiseman, Doan and Wilson⁹ state that there is no abnormality in the bone marrow except that which may reflect rapid and excessive loss of blood. These writers further say that the megakaryocytes have never been numerically decreased or qualitatively altered in any of their cases of true thrombocytopenic purpura. In a more recent study of the bone marrow in 3 cases of this disorder Valentine¹⁰ reports that marked depression of platelet-forming activity by the megakaryocytes was noted and that there was a moderate increase in the degenerative forms of these cells. Other writers, including Dameshek¹¹ and Limarzi and Schleicher,¹² have reported changes in the megakaryocytes which have disappeared following splenectomy. With this disagreement among those who have had considerable experience in the study and evaluation of bone marrow preparations it is certain that one without that experience should venture no opinion. However, some of the clinical facts can be explained by the hypothesis that in early hypersplenism there may be thrombocytopenia without bone marrow damage. This could bring about the syndrome of idiopathic purpura, as illustrated in the first two cases, and with the removal of the splenic factor by operation complete recovery

occurs. We may assume that in some cases, either through a greater degree of intensity or a longer duration, hypersplenism will have a 'fatigue effect' on the megakaryocytes, resulting in a depression of the marrow cells and further interference with platelet formation. Such an effect, conditioned by individual susceptibility, duration and intensity, might well explain the extreme variability not only in the clinical course of these patients but also in the interpretation of bone marrow findings.

BIBLIOGRAPHY

1. Patek, A. J.: Thrombocytopenic purpura and some other hemorrhagic diseases; *Am. J. Med. Sc.*, 191, 723, 1936.
2. Hurd, R. W. & Jacox, R. F.: Thrombocytopenic Purpura developing as a complication of Sulfathiazole and Sulfadiazine Therapy; *J. Am. Med. Assn.*, 122, 296, (May 29) 1943.
3. Rappaport, A. E., Nixon, C. E. & Barker, W. A.: Fatal Secondary Toxic Thrombocytopenia due to Sodium Salicylate; *J. Lab. & Clin. Med.*, 30, 916 (Nov.) 1945.
4. Nudelman, P. L., Leff, I. L. & Howe, C. D.: Thrombopenic Purpura following Quinidine; *J. Am. Med. Assn.*, 137, 1219, (July 31) 1948.
5. Morrow, W. J.: Hemorrhagic Purpura following Scarlet Fever; *Arch. Ped.*, 62, 255, (June) 1945.
6. McCarthy, F. B. & Wilson, R., Jr.: The Blood Dyscrasias following the Arsphenamines; *J. Am. Med. Assn.*, 99, 1557, (Nov 5) 1932.
7. Troland, C. E. & Lee, F. C.: Thrombocytopen; *J. Am. Med. Assn.*, 111, 221, (July 16) 1938.
8. Paul, J. T.: The Effect of Splenic Extracts from cases of Essential Thrombocytopenic Purpura on the Platelets and Hematopoietic Organs of Rabbits; *J. Lab. & Clin. Med.*, 27, 754, (March) 1942.
9. Wiseman, B. K., Doan, C. A. & Wilson, S. J.: The Present Status of Thrombocytopenic Purpura; *J. Am. Med. Assn.*, 115, (July 6)
10. Valentine, E. H.: Idiopathic Thrombocytopenic Purpura. A study of 3 cases with special reference to changes in the Megakaryocytes; *Am. J. Med. Sc.*, 214, 260, (Sept.) 1947.
11. Dameshek, W. & Miller, E. B.: Megakaryocytes in Idiopathic Thrombocytopenic Purpura, a Form of Hypersplenism; *Blood*, 1, 27, 1946.
12. Limarzi, L. R. & Schleicher, E. M.: Reaction of the Peripheral Blood and Bone Marrow in chronic hemorrhage and in Essential Thrombopenic Purpura; *J. Am. Med. Assn.*, 114, 12, (Jan.) 1940.

Hyperparathyroidism

REPORT OF A CASE

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Hyperparathyroidism is usually caused by a tumor of the parathyroid gland, one or more glands being involved. It presents a rather characteristic syndrome, and it is remarkable that the history of this disease is of such short duration, because, although it was suspected previously, the first autopsy reports confirming such a diagnosis were in 1884. Only after the parathyroid hormone was discovered in 1925 was a patient operated on and a tumor removed. (Mendell, 1926). 1, 3, 4.

Following this only 12 cases were described from 1929 to 1942 at the Mayo Clinic. However, since 1942 51 cases have been found at Mayo Clinic and the disease is becoming more frequently recognized.²

The activation of these tumors is based on some unknown cause. It has been proved rather conclusively that sex, age, climate, and diet have no particular influence on the incidence. Renal insufficiency may play some part in secondary hyperplasia of the glands due to phosphorus retention with calcium suppression, such as occurs in renal rickets. Diagnosis is not difficult if the following factors are kept in mind: (1) symptoms opposite those of tetany, i.e.: easy fatigueability, generalized muscle weakness, lack of coordination, bradycardia, constipation, (2) pain in the bones, (3) frequent pathological fractures, (4) in about 70% of cases urinary lithiasis with associated symptoms, and (5) cysts of the bone are not infrequent.

The differential diagnosis includes the following: multiple myeloma, rickets, renal rickets, osteitis cystica, multiple carcinomatosis, Cushing's basophilic adenoma, and high vitamin D intake over a long period of time.

The preoperative diagnosis depends on the characteristic changes in the values for calcium and phosphorus, and radiological evidence. The final diagnosis rests upon exploration of the neck, and the pathologist's confirmation of a parathyroid adenoma.

REPORT OF A CASE

Bruther M.: This 38 year old colored female was admitted with a diagnosis of osteoporosis of undetermined origin. For the past six years she had had increasing weakness and for the three months previous to admission she had noted that her front teeth were becoming progressively loose. She was

beginning to have vague pains in the flanks and lower chest and for several weeks before admission had been bedridden. During this time she passed three small urinary calculi, measuring 2 to 4 mm, which were soft and friable. Family history was non-contributory.

PHYSICAL EXAMINATION

T-100, P-90, R-20, BP-105/60. The head was remarkable in that the fronto-temporal regions could be depressed with the fingertips due to the softness of the skull, but would snap back when released. The teeth were in good condition but very soft and easily depressed, and the 6th and 7th ribs were apparently fractured in the left anterior axillary line. Examination of the abdomen, pelvis, and extremities was essentially normal. The reflexes were all markedly hypo-active.

LABORATORY FINDINGS

Blood: RBC 3,500,000, WBC 8,700, Hbg. 70%
Urine: Innumerable WBC, 2-plus Albumin.
Kahn: Negative.
NPN: 12.6 mgm.
Creatinin: 2.1 mgm.
Calcium: 12.3 mgm.
Phosphorus: 27.5 mgm.
Serum Acid Phosphatase: 3.05 mgm.
Bence Jones Protein: Negative.
P. S. P. test: 42% at the end of two hours.

X-RAYS

Skull: Showed marked decalcification.
Chest: Marked decalcification with fracture of several ribs in the left anterior axillary line.
I. V. Urogram: Marked calcification of the calices of the kidneys, with very slow kidney function.

HOSPITAL COURSE

Exploration of the neck revealed a tumor of the right lower parathyroid gland which measured 2 x 3 x 5 cm. and weighed 8.2 grams, and a smaller tumor of the left upper parathyroid which measured 1 x 2 x 2 cm., and weighed 0.5 gram. Pathological examination revealed these to be true adenomata of the parathyroid. Postoperatively, the patient was given parathyroid hormone and intravenous calcium. She was quite nervous for three or four days and the blood calcium level dropped to 6.4 mgm., but the patient did not go into tetany, and after this showed steady improvement. The teeth became firmer, pain

in the flanks and ribs disappeared, and X-rays of the skull one month postoperatively revealed considerable recalcification. However, the P. S. P. was 36%.

Since her discharge from the hospital, the patient has refused to return to any of the follow-up clinics, (G. U., Surgery, Medicine), because she "feels so good."

SUMMARY

A case of hyperparathyroidism due to two distinct parathyroid adenomas is presented. The diagnosis is

discussed and exploration of the parathyroid region is advocated in all cases of suspected hyperparathyroidism.

BIBLIOGRAPHY

1. Tyce,; Practice of Medicine.
2. Surgery Gynecology and Obstetrics, Aug., 1948, Vol. 87, 172.
3. Boyd, William.; Pathology of Internal Disease, 1945.
4. Babcock, W. W.,; Principles and Practice of Surgery, 1944.

Modern Psychiatry In General Practice

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Modern psychiatry offers many useful concepts for the general practitioner. A grasp of these concepts are of invaluable assistance to him as an aid in diagnosis and therapeutics. It is possible for the practitioner to offer increased aid for the neurotic component of almost any physical complaint. Even more, the practitioner can help himself and get an understanding of what comprehensive medicine may mean. Any physician may discover neurotic aspects of his own personality that he had not suspected existed. This cannot be learned by ordinary study but only by specific efforts in this direction, involving the development of increased awareness in interpersonal relations. Only in this manner can any individual achieve self-reliance and self-respect through self understanding. However, there are limits to what any individual can achieve through his own efforts, because no one can adequately be objective enough about himself. Physicians are needed with increased psychiatric understanding, not only because of the increased demand for psychiatric services but as leaders in modern medicine.

Increased awareness of what goes on in interpersonal relations gives the physician a new feeling of the dynamic qualities and the human values of the doctor-patient relationship. He is introduced to broader patterns of human motivation and to the more general causes of emotional disturbances, and other illnesses. He can learn the more easily understandable methods of psychotherapy in order that he can treat a share of such illnesses as well as learn to recognize the more malignant forms of psychopathology in order to refer them for more comprehensive psychotherapy.

Any individual who consults a physician for any complaint manifests some degree of insecurity. It is of the utmost importance that the physician take adequate cognizance of this factor in the presenting complaints. Too often all too much emphasis is placed on the physical symptoms. The patient

however presents mental symptoms or attitudes in addition to the physical symptoms. It is these attitudes or symptoms that are the subject of this discussion. The nervous symptoms should not be considered as just "neurotic" but considered an integral part of the total problem with all that the concept implies.

Attitudes at any given moment are the result of life experiences up to that moment. These attitudes are therefore acquired and not inherited as are intelligence and physical characteristics and therefore can be modified. This is analogous to efforts to change physical symptoms through direct or indirect intervention on the part of the physician. It is quite probable that all of us are born potentially compassionate and creative to some degree, but later experiences that lead to undue frustration may alter these tendencies. When the physical needs of the infant are met, the body develops properly. In a similar manner when the mental or emotional needs of the infant are met, the attitudes develop properly. The most basic need is for security or freedom from fear and worry. Such security is derived from the most significant person in the infant's environment, usually the mother, through perception of attitude. Such sensitivity to the attitudes of others is always present to some degree throughout life. We are all influenced by public opinion or group pressure, which is perception of attitude multiplied many times.

The degree of security which the individual acquires determines the degree of emotional maturity that he can achieve through experiences that make for emotional maturity. Emotional maturity or self-reliance can not come chronologically as does physical maturity. Ease in living is achieved to the degree that the individual can be at ease in interpersonal relations. Such ease can be achieved to the degree that he can increase awareness of what goes on in himself in interpersonal experiences. It

is only by practicing such awareness that he can achieve emotional maturity which involves self-reliance, self-respect with the ability to accept responsibility through awareness of motivation.

All of us are aware of meaning in verbal communication. Only by practice can we develop awareness of a more insidious form of communication especially active from earliest infancy, communication through perception of attitude. An individual can be anxious or bothered to the degree that it can be perceived by someone else and not even be aware of it himself. We can have feelings about what we hear from a patient. We can reveal these feelings to the patient without realizing our own feelings. This part of us is actually a stranger to us. It can only be discovered by increasing personal awareness and with the help of others. This is the nature of psychotherapy. As we become better acquainted with our unsuspected reactions to others we eventually may discover that they are actually a reflection of our attitudes toward ourselves.

When an individual is questioned as to the reason for a thought or an act, he may really justify the process rather than really explain it. This leads to self-deception through justification which we call rationalizing. This is self evident in a more blatant form but may be so insidious as to be very deceptive to the individual and to others.

When we are confronted with a decision it may be difficult to take a categorical attitude. On further analysis the choice of decision may be what we want to do or what we ought to do. When we don't do what we ought to do, we may experience feelings of guilt or a troubled conscience. What we ought to do is really foreign to us but has become a part of us through some frustrating experience in the past.

Usually we are prone to attempt to achieve self assurance through some form of successful accomplishment. There is however no end to this for each accomplishment is a bridge to a need for further accomplishment. In other words, if we are led to a need for accomplishment through self doubt, we are actually perpetuating the doubt through further accomplishment. As indicated earlier, self assurance is only possible through self understanding.

The individual reflects toward others those attitudes which he really has toward himself. When he has not achieved adequate self respect, he cannot adequately respect others. This may result in feelings of guilt or a troubled conscience and lead to an undue need for the respect of others. Any frustration in this dependence on others leads to some form of hostility as, e. g., "I need you, you don't satisfy my need, therefore I hate you." Such conflicts make for tension, both local and general and are the basic cause of even physical symptoms. We

have all had the experience that tension is more exhausting than exertion.

There has been increasing interest in so-called "psychosomatic medicine" although it is implied that physical symptoms have an emotional basis but may erroneously lead to differentiating between mind and body. We all know how rage leads to changes in appearance, pulse and blood pressure and fear to almost opposite symptoms. Psychosomatic medicine does imply that because the individual cannot adequately adapt to his environment, he develops physical symptoms.

In pediatrics, feeding, excretory problems and allergies are common examples of psychosomatic complaints. Children learn by imitation and identification of significant people in their environment. The former is conscious and the latter unconscious. Illness in children as in adults is accompanied by anxiety. This is further complicated by anxiety in the parents. Undue oversolicitude is usually indicative of unrecognized latent hostility. The parent has a latent tendency to reject the child and keeps this from becoming conscious by undue concern for the child. It is surprising how quickly children can respond to some change of attitude in the parent. Children all have natural tendencies that may come into conflict with cultural patterns of the parent. This may give rise to punishment that is mistaken for discipline. Discipline is learning with satisfaction and is preferable to punishment. On the other hand, lack of discipline leads to undue aggressiveness on the part of the child which in turn leads to anxiety in the child. Life at its best is extremely frustrating to the child. It therefore behooves the parents to set the examples they expect their children to follow. Consistency is the desired virtue in this respect and a moral attitude is never in order. Nothing is right or wrong in itself but only because it may lead to undesirable results. Practical suggestions are to always have the parent present when a child is undergoing anaesthesia and when the child recovers. It hardly bears mentioning that the child should be prepared for any unpleasant experience and never seduced to them. The rapid healing and recovery of children make for even more satisfaction when there is a personal as well as a professional interest in the patient by the physician.

Surgery and medicine offer many opportunities for psychosomatic understanding. For example, peptic ulcer is called "sergeant's disease," in the English army. For some reason gastro-intestinal complaints have been much more frequent in the recent conflict compared with the hysterics and exhaustion syndromes in the first world war. Recognition of the effect of attitudes on the presenting symptoms calls for caution in the use of medication. Attitudes cannot be significantly influenced by medication or physiotherapy. Such symptomatic therapy is indicated when it is recognized only as a means to an end. An example is the use of sedative to relieve

secondary anxiety arising from the symptoms. Tensions may be general or localized as, myositis, rheumatism, gastritis or colitis. When the etiological factors are recognized as psychogenic, comprehensive psychotherapy, usually beyond the ability of the general practitioner is indicated. The gratitude of the patient is adequate compensation for referring the case. Essential hypertension involves emotional difficulties in living and may significantly contribute to early arteriosclerosis. Allergies in adults as in children have emotional components that predispose to as well as result from the symptomatology.

Sex problems are often recognized after marriage and may include promiscuity, impotence or frigidity and perversions. Sexual behavior is symptomatic rather than causal. The attitudes behind the symptoms are always basic in consideration for treatment and are an index of attitudes toward other problems in living. When the marriage partners get along out of bed they will always get along in bed but the reverse never holds true for very long. Worry about masturbation is the only undesirable consequence of the act. Perversions are only extreme examples of emotional immaturity manifesting itself in the sexual sphere. Sexual maturity can only be achieved along with emotional maturity. It is a common experience to have menstrual disorders as well as even sterility improve coincidental to psychotherapy for other reasons.

Finally in the field of geriatries psychosomatic understanding is especially helpful. As the individual reaches senility difficulty is experienced in utilizing usual mechanisms of escape. Often the individual reaches old age before he discovers loneliness resulting from lack of ability for intimacy, a cardinal symptom in all neurotic difficulties. In a general way people are most fearful of death when they have not yet learned to live. Although the aged are less flexible they are usually not inflexible.

In conclusion it has been presented that individuals may experience general or local tension, arising from emotional conflicts that are engendered by difficulties arising from interpersonal and

eventually intrapersonal relations in their environment. These tensions can give rise to physical symptoms and even pathologic changes in tissues. Understanding the influence of emotional attitudes is necessary to understand the problem and explain it to the patient. It isn't enough to tell the patient his symptoms are mental in origin as this may convey the idea he is only imagining his symptoms that are so real to him, and may evoke anger or discouragement. The patient should always be given ample opportunity to talk freely. This alone often enables him to recognize his irrationality and thus see things differently, the important step in psychotherapy. On the other hand, all the factors contributing to the problem will combine to resist any change. He will also eventually reveal to the physician those attitudes that bring him into conflict with others. As the patient achieves some degree of emotional rather than intellectual insight, it often leads to emotional displays that precede the real changes in attitude. Reading literature is of very limited value as no one can be adequately objective about himself.

The difference between sanity and insanity is only a matter of degree as is true of somatic health and disease. Too often psychiatric consultation is delayed when suspected until medication or even operative procedures have been unsuccessful. The limited scope of medication to treat symptoms rather than change attitudes should be explained to the patient to avoid fixating the mind on the symptoms. This encourages the patient to look for the attitudes behind the symptoms. The patient should, if possible, be spared non-medical advice. This only encourages further dependency on the physician and only perpetuates the basic problems. In his discussion with the patient, the physician should maintain the role of objective factual observer and never the role of critic. Consultation of the practitioner with a psychiatrist may often enable the practitioner to continue to treat the patient with the occasional help from the psychiatrist. The greatest satisfaction to a physician who is thus oriented is the continued achievement of self understanding toward approximating what had been only potential satisfactions in living.

The General Practitioner In Rural Practice

A. W. BROWNING, M.D., ELLOREE, S. C.

We have numerous problems affecting medical care in the United States, but none is so serious as the situation involving the supply of physicians for rural practice.

There is a great tendency to believe that because there is a scarcity of physicians in certain rural areas, more physicians should be graduated from medical schools to take care of this deficiency. If we know nothing else about maldistribution, we at least know that the problem will not be solved simply by training more doctors, which is needed, but surveys of states which have intensified their medical training programs show that medical school graduates still flock to urban areas.

One of the principal reasons for the shortage of physicians in rural areas is that it is difficult for doctors to practice modern medicine in country districts, as they would like to because of the lack of facilities. On the other hand, there is ample evidence that a great many more doctors would go into rural practice if they had the hospital facilities, the money, and other opportunities that the rural communities do not at the present time afford. In fact, people seem to feel that doctors practicing in small town-rural areas are not entitled to like fees for their work as city physicians for the same kind of work.

The general reluctance to enter rural practice is reflected in the programs of the medical schools themselves. The relatively higher monetary reward of medical and scientific research and specialization is siphoning off potential general practitioners from the rural areas.

There is no single solution to the problem. There must be a multiple approach.

First, we need a coordinated program for the development of rural health facilities which will make it possible for physicians to give modern and complete medical service in rural areas. This means community and state planning, and in many, if not all areas, it means a measure of Federal or State assistance for cheap ward beds, free if necessary, which we should favor—somewhat in line with the Hill-Burton Bill. The medical isolation of physicians should be overcome; much can be done in this regard also through an integrated, well-equipped medical clinic building provided through taxation if necessary and let the profession run the same.

Second, we need to change some of our traditions and "folkways" in rural areas—we need to change the kind of attitude, for example, which causes rural people to go to distant cities to visit urban doctors or quacks in the daytime, using their local physicians

for night and emergency work. As a result, much of the present reluctance on the part of physicians to engage in rural practice stems from the fact that they do not receive adequate cooperation and support from the rural people. In this connection, I wish to quote what the President of The American Medical Association said at our First Rural Health Meeting here.

He said, "One of the causes of our problem is illustrated by a story I heard from a reliable source some time ago. It is about a country doctor who was located at a country crossroads in one of the states in the Middle West. He was happy there and busy, but the roads over which he traveled on horseback or by buggy became paved roads. The farmers bought cars and so did he. In a short while he was not busy. He discovered that his patients were going to a large town some miles away for their medical care.

He then posted a notice on his office door that he was going to that town. The people in the community made a loud protest. His reply to their protest was that many of them were going to this town for medical care, since the roads had been improved, and that they were calling him only at night or in emergencies. This fact they could not deny. He had no further trouble."

This, the members of farm and other organizations present should go home and tell their people.

Third, we must make a new approach through the medical schools. Students might be carefully selected from rural communities and partially or wholly subsidized, as South Carolina and some other states are doing, under the condition that they engage in practice in rural communities. Another device could be that one year of instruction in rural practice be required of medical school graduates as a substitute for the present one year period of hospital work. After having done this, many would likely remain in these small town and rural areas.

Fourth, there should be an attempt on the part of both the medical school and the communities concerned to keep in constant touch with prospective practitioners during and after their school years for the purpose of attracting physicians to communities where they are needed. This follow-up and "courtship" technique has been effective in Tennessee.

Finally, local community income guarantees may be necessary in certain areas. If you want a preacher, you go out and seek one and show him every encouragement. Do the same with your doctors.

There are other factors of importance, but if efforts could be directed along these channels, a real start toward the solution of the problem of maldistribution of physicians might be achieved.

(Presented at the section on The General Practitioner in Rural Practice at the Rural Health Conference in Chicago, Feb., 1949.)

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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MAY, 1949

BENJAMIN O. WHITTEN

Among the unsung heroes of South Carolina medicine, the name of Dr. Benjamin O. Whitten will stand high. As Superintendent of the State Training School at Clinton he has rendered the state a truly noble service. Quietly and patiently he has, against terrific odds, ministered to the unfortunate children of the state. The facilities of the institution are completely inadequate to care for the large number of children entrusted to its care. There are not nearly enough trained workers to furnish the special care and instruction which the children need. And yet the School continues to function in a manner which reflects credit to the state. We know of no task which would be more discouraging or would lend itself more to a spirit of giving up than that of caring for a group of children who, in so many instances, are mentally retarded or mentally deficient. No one could have blamed Dr. Whitten for having quit his job many years ago. That he has continued at the head of the institution through the years, doing what he could with the means at hand, is evidence of the stuff out of which this man is made. He is a man of whom his colleagues can truly say—he is a real physician.

NATIONAL PHYSICIANS COMMITTEE

After ten years of strenuous activity, the National Physicians Committee has felt that its aims have been accomplished and has announced its self-liquidation. Here is the official statement issued by its chairman, Dr. E. H. Cary, on April 14, 1949.

"Ten years ago, a group of officers and fellows of the American Medical Association realized that the American Medical Association was not as active in certain functions as was deemed necessary, some of which seemed at that time inappropriate for the American Medical Association to perform. As a result, the National Physicians Committee for the Extension of Medical Service was created and has worked during these intervening years within the policies established by the House of Delegates of the American Medical Association.

"Several times during those years, the House of Delegates has expressed confidence in the work of this organization.

"Two years ago, a Committee of the House of Delegates reported that "the American Medical Association should and must do its own public relations work."

"In December, 1948, the House of Delegates took action to create a new agency to carry on public relations activities and to further the extension of medical care. This new agency has been created and is functioning. The program as planned and now being carried on by the American Medical Association represents the fulfillment of the objectives for which the National Physicians Committee was created and toward which it has been working.

"Its aims having been accomplished, the Board of Trustees of the National Physicians Committee met in Chicago on April 10, 1949 and voted (1) to approve the action of its Management Committee in authorizing cessation of all activities as of April 1, 1949 and (2) to liquidate the affairs of the National Physicians Committee in an orderly manner.

"It planned further to hold its next meeting in Atlantic City in June, 1949 and at that time to consider further action looking toward dissolution of the organization.

"During its ten years of activity, the National Physicians Committee has brought about the formation of forty-seven state committees of physicians and forty-six state committees of dentists, in addition to other local organizations, that have functioned vigorously and well. The Board of Trustees now suggests to the physicians making up the personnel of these state committees that they offer their services to the new American Medical Association agency."

SCHOOL HEALTH SURVEY

The secretary of each local medical society will soon receive in the mail a questionnaire on school health services in his community. The American Medical Association in cooperation with the U. S.

office of Education is making a study of school health services through its Bureau of Health Education. The survey is a preliminary step in efforts designed to bring about improvement of school health programs within the framework of the private practice of medicine. For this reason, it is most important that each local medical society complete and return the questionnaire.

The U. S. Office of Education in Washington will

concurrently query the schools. Two different questionnaires which supplement and reinforce each other and contain no duplicate questions are being used. The information requested is needed to determine present strengths and weaknesses in school health services, to indicate needs, and to point up action for the future. The questionnaire has been tested prior to printing and all unnecessary questions eliminated.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

PRESIDENT RENEWS CALL FOR COMPULSORY BILL

The President of the United States on April 22nd called upon Congress again for the immediate enactment of a 10-year health program. Such a program was proposed in a lengthy report presented to the President last September by Federal Security Administrator, Oscar Ewing.

The principal feature of the program, of course, and that upon which Mr. Truman laid the greatest emphasis in his three thousand word message, is compulsory sickness insurance. He said this was necessary to end "unnecessary human suffering."

Officials were quoted as estimating that such a plan might cost as much as \$6,000,000,000 per year. It was made clear that the revenue to pay the cost would be lifted from the paychecks of workers, supplemented by payroll taxes against the employers.

Pointing to the spread of voluntary health insurance plans throughout the country, the President reasoned that this was proof of the understanding by the people of the advantages of health insurance and of their desire for its extension, but he brushed aside the voluntary plans with the statement that unfortunately they have "proved inadequate to meet the need." He ignored the rapid and widespread growth in the number and efficacy of the plans within the past very few years since the principle of voluntary non-profit insurance has been introduced. Nearly one-third the entire population, or 52,000,000 insured individuals under voluntary contracts is quite a substantial number despite the fact that the President appears to regard it as negligible.

The President, of course, is entitled to his view. He represents a political trend about which he has been perfectly frank and for this he should be given credit. The compulsory sickness insurance program was one of the important planks in the platform on which he was re-elected. We believe that at heart he is sincerely interested in the lot of the common man, the people on the lower economic level. Such a feeling is bound to color his thinking and would be sufficient reason to the President to fight for his program with all the determination of which he is capable.

But the part of his statement which appears to us inexcusable and as branding the entire effort with the mark of political opportunism, is the representation that the national cost of medical care and health services might be reduced by such a national program administered by the Federal Government.

THE HILL BILL FOR VOLUNTARY HEALTH INSURANCE

The Bill introduced in the Senate of the United States on March 30, 1949, by Senator Lister Hill of Alabama, (S. 1456), represents a far more reasonable approach to the effort at solution of the health problem than any of the Administration proposals. In fact, it appears to this observer, at first blush, to offer substantially, a very satisfactory plan of Federal aid for medical care and health services.

Co-authors of the Bill with Mr. Hill are Senators O'Connor, Withers, Aiken, and Morse. The Bill was referred to the Committee on Labor and Public Welfare. Senator Hill, it will be recalled, was co-author of the Hill-Burton Bill which became Public Law No. 715, providing for the national program of construction of hospitals and medical centers, following a survey of the existing facilities of this type, likewise financed by Federal aid.

S. 1456 would be referred to as the "Voluntary Health Insurance Act," and is obviously designed by its authors as a direct answer to the proposals for compulsory insurance by Messrs. Wagner, Murray, Truman, Ewing, et al. It proposes to amend the Public Health Act by the addition of a new title: "Title VII—Hospital and Medical Care."

Passing over the general statement of purpose of the Bill and the definitions, the measure would provide for a system of hospital and medical care under State plans. Sums made available through Federal appropriations, authorized under the Bill, would be used in making payments to States submitting and having approved by the Surgeon General of the Public Health Service, plans for carrying out the purpose of the measure.

General Regulations

The State plans would be required to meet uniform regulations prescribed by the Surgeon General,

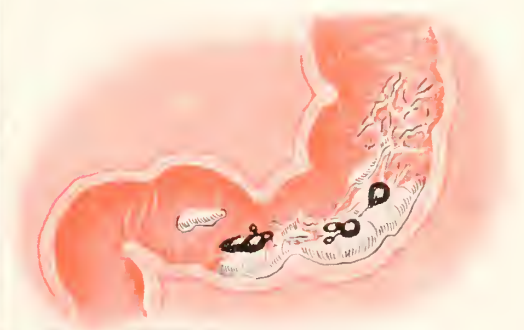
TREATMENT OF CONSTIPATION IN mucous colitis

"The treatment of the constipation in mucous colic does not differ from the treatment of uncomplicated constipation. It is, as always, of great importance to avoid irritating aperients, . . . The stools should be rendered soft and more bulky and therefore more easy to expel with . . . and unirritating vegetable mucilages."

—Hurst, A., in Portis, S. A.: Diseases of the Digestive System, ed. 2, Philadelphia, Lea & Febiger, 1944, p. 692.



MUCOUS COLITIS. In this x-ray is shown the distinctive string-like appearance of the descending portion of the lower bowel in mucous colitis, a condition frequently accompanying severe degrees of spastic or atonic colon. In the sagittal section is shown the over-secretion of mucus adhering to the bowel wall.



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with respect to:

- (a) Eligibility of persons.
- (b) Types of hospital and medical care provided.
- (c) Standards for participation of voluntary prepayment plans, non-profit and otherwise.
- (d) Method of enrollment in voluntary prepayment plans.
- (e) Methods of administration.

Federal Financing

As in the case of the Hospital Construction Act, Federal aid under the measure would be only partial, and funds provided from that source would have to be matched by the States on a proportional basis, specifically outlined in the Bill. The percentage of Federal aid in each State would be based upon the relationship of that State's per capita income to the per capita income of the continental United States (excluding Alaska). In no case, however, could the Federal aid exceed 75 percent, or be less than 33-1/3 percent of the total cost.

The Federal percentages would be promulgated every other year by the Surgeon General, on the basis of the records as to the per capita incomes for the three most recent consecutive years.

Administration

While administration of a plan in each State would be carried out by the agency created or designated within the State for that purpose, general uniformity would be provided through administrative regulations made by the Surgeon General, with the approval of the Federal Security Administrator.

The Surgeon General would be directed to "consult with" a Federal Hospital and Medical Care Council, to be created under the Bill, consisting of the Surgeon General and ten members appointed by the Federal Security Administrator. Two of the ten would be doctors of medicine, and two would be hospital administrators "outstanding" in their respective fields. Two members would be persons experienced in the administration of voluntary prepayment plans for hospital and medical care, and the other four would be appointed to represent consumers of hospital and medical care. Members of the Council would be appointed for five years with the terms of office staggered. While the Council would clearly serve in an advisory capacity only, it would have the right to appoint special advisory and technical committees, and to meet upon request of any four or more of its members. Otherwise, meetings of the Council would be on the call of the Surgeon General, but not less than once a year.

State Plan

The basis of operation of the State plans would be through the medium of voluntary prepayment hospital and medical care plans. Provision would be made for certification by an appropriate State agency of all persons who are unable to pay all or any part of the subscription charge of a prepayment plan; for the issuance, from time to time, of service cards to the individuals and their dependents so certified, and for the furnishing of hospital and medical care

to persons holding such service cards.

The State plan would provide for the making of satisfactory contracts or arrangements between hospitals and nonprofit prepayment plans (as Blue Cross now operates) for the acceptance by the plan of liability for payment for all essential services following the admission of a member of the plan, and would require that payment for hospital and medical care under such arrangements should be on a basis mutually agreeable to participating doctors and hospitals, and the State agency. The State agency would repay to the plan the full amount of its payments for hospital and medical care, plus reasonable administrative expenses to be agreed upon.

The plan would also provide methods, and presumably standards, for determining eligibility of persons to receive service cards, and for obtaining partial reimbursement therefor, according to the financial ability of the individual to pay subscription charges.

Any person drawing unemployment compensation and enrolled in a participating voluntary prepayment plan, would have his subscription charges for the period during which he receives unemployment compensation paid out of funds available for hospital and medical care, such payments to be made directly to the plan.

Provision would be required for pay-roll deduction of subscription charges in voluntary plans for the employees of the State, or political subdivision, upon request of the employees.

The State plan would also be required to provide for surveys with respect to the following: the existing enrollment in voluntary prepayment plans, and development of a plan for stimulating and encouraging such enrollment, with emphasis on employer participation, and enrollment of persons in rural areas; existing diagnostic facilities, and necessary additions to such services to make them available to all persons; existing facilities, services and financing for the care of mental, tuberculous, and other patients hospitalized for long periods of time.

Provisions would also be made for a survey of areas in the State unable to attract practicing physicians, and the State plan should recommend methods for encouraging physicians to practice medicine in such areas.

Safeguards for restricting the use or disclosure of information concerning recipients of aid under the plan, would be required, and determination of eligibility would be made, where possible, in advance of the need for hospital and medical care, in order to avoid the much maligned "means test."

The foregoing are the highlights of the Bill, some aspects of which are confusing and need clarification. Provision is made, of course, for periodic reports by the State agency to the Federal authorities, as to the manner in which the regulations are being complied with; for the establishment in each State of a Hospital and Medical Care Authority, and for meeting standards with respect to personnel, and otherwise, as prescribed by the Surgeon General. Most of these

provisions, however, are of course essential for the operation of any system financed, in whole or in part, by the Federal Government on a nation-wide basis. In the main, and as Congressional Bills go—certainly, as compared with provisions for compulsory health insurance—the measure is much more simple and direct. It is designed to furnish Federal funds to assist the States in meeting the medical and hospital requirements of their citizens, and to do so through established media, and according to principles already recognized, accepted, and long since in operation in the United States.

More careful study may disclose serious defects, but at this point, we believe the Bill is worthy of serious and generally favorable consideration.

HIGH TAXES LOWERING LIVING STANDARDS

Dr. R. B. Robins of Camden, Arkansas, a member of the House of Delegates of the American Medical Association, and Democratic National Committeeman for the State of Arkansas, recently took the task of Chairman of his political party, in a sharply worded telegram, concerning the proposals for Compulsory Sickness Insurance.

Senator McGrath, who led the Democrats in the successful drive to reelect President Truman last fall, had, in his official capacity as Chairman of the Democratic National Committee, called on the Democratic leaders throughout the country to support the proposals. Dr. Robins objected in no uncertain terms to what he regarded as the misuse of the Senator's official position within the Party to try to influence support for a program on which opinion is sharply divided.

Dr. Robins made the interesting charge that "The Federal Government, by extravagant tax demands which constitute a dangerous drain on family income, is forcing lower living standards on millions of the American people, and is taking away earnings which they badly need for adequate diet, clothing and shelter."

"That's the most serious health and economic problem which confronts this country," said Dr. Robins, "and it's about time we got it out in the open and talked about it. The compulsory health insurance program is a pitiful political attempt to treat symptoms, instead of getting at causes."

Dr. Robins declared: "The real problem in most American homes is the tax bill, not the medical bill. In most income classes, according to the findings of the Brookings Institution, the cost of medical care represents about 4 or 4.5 per cent of the family income. But the tax bill is draining away from 20 to 30 per cent of earnings, even in the low and middle income groups. It's a little hypocritical, under the circumstances, for Federal Security Administrator Oscar Ewing to be beating the drums for compulsory health insurance as a cure for the people's ills. If he wants to make a real contribution toward improving the public health in America, he should do some-

thing about cutting costs in his own towering bureaucracy and in the other departments in Washington which are literally taking food out of the mouths of the people. In lower income groups, malnutrition is at the bottom of much of the disease in America and Oscar Ewing should know it."

"The real reason for the high-pressure drive for compulsory health insurance," said Dr. Robins, "is that the supporters of political medicine see the opportunity for establishing a medical bureaucracy slipping through their hands. More than 52 million people in this country already have provided themselves with voluntary health insurance to cushion the economic shock of illness. That's a splendid start toward meeting the problem and our campaign will be designed to make all the people of the country health insurance conscious—and let them know that the finest kind of medical care can be bought on a pre-paid basis, without government interference or political meddling.

"The voluntary health insurance systems, during the past ten years, have had a phenomenal growth—and the real demand is for voluntary health insurance, not compulsory. Mr. Ewing undoubtedly knows that, and within the next two or three years, if government stays out of the business, the problem will have been largely resolved. That may explain the great haste in Washington to jam through a compulsory health insurance program at this session of Congress. The socializers see their opportunity rapidly disappearing."

POLITICS AND MEDICINE*

*Reprinted from Editorial section of the Journal of the Michigan Medical Society, February, 1949.

Careful reading of Federal Security Administrator Oscar R. Ewing's report, shows how utterly inconsistent are his arguments. In the first two sections of the book he tells how completely inadequate is the present medical care of the American people. He admits their health is the best in the world, but claims that we know things about medicine, infectious diseases, cancer and hospital care that would eliminate a tremendous amount of sickness; would save an estimated \$27 billion a year in loss of income, and 325,000 deaths which could be prevented. He says the average income of 50 per cent of the American people is under \$3,000 a year, but in figuring the loss to the nation of labor-years due to sickness, he uses the earning capacity of \$3,800 per year. He says the expense of caring for sickness is an extra and unbearable load for these people, but the whole country could carry it if distributed among the whole people in proportion to their ability to pay. Yet he proposes to assess the tax or the premium on only the first \$4,800 of income. That does not distribute the burden equally, or according to the ability to pay, but *establishes an income tax for the lower income group*. He criticizes the voluntary plans for not covering the indigent and those of extremely low income who cannot afford to pay a premium of

\$48.00 a year for a family. But in his proposal he leaves this same group uncovered unless local relief or welfare organizations, governmental or voluntary, will pay the premiums which they could do more easily with our present voluntary non-profit plan.

He pictures the health condition with unlimited care, hospital, medical, dental and others, for whom-ever wishes to seek that care. But he says the medical profession at present is woefully undermanned to take care of the present load. He plans a three-year adjustment period after this new law is enacted and before it comes into effect, during which time hospital facilities, medical, dental, nursing and other personnel, will be provided. He admits the medical schools cannot carry a much bigger load than they do carry. He admits the establishment of new schools would be a difficult and slow process because of building problems and inadequate teaching personnel, yet he proposes to do this job. He claims we are short 900,000 hospital beds and that we now have about 900,000 effective hospital beds. He proposes new hospitals, new "health clinics" in every community as low as 500 persons.

Mr. Ewing quotes the old statement that 40 per cent of the counties have no hospitals, and says that, ideally, nobody should be more than one hour away from a good hospital. There was a survey some years ago with a published map and a 30-mile circle drawn around every general hospital in the United States. There were a few spots other than in remote mountain districts which were not included in some of these circles. We believe a *careful* study would show that the number of people in the United States more than one hour away from a hospital is negligible. Mr. Ewing paints a glowing picture of the ideal which we should have, based upon all the knowledge we do have, and blames our present system of health care, including the voluntary plans, for not attaining that 100 per cent ideal. He admits that under his plan this ideal could not be reached for approximately forty years because it will take that long to reach the goal which he has set up, unless he can work wonders in creating hospital facilities, medical training facilities, and personnel. The same applies to dental and nursing fields. Mr. Ewing is a shrewd advocate of an ideal state, gives only begrudging credit for what has been done and at the same time points out the inadequacies. He claims his proposed plan will meet all these objections, but in the same paragraph admits that there must be some curtailment.

REPORT OF THE COUNCIL ON MEDICAL SERVICE OF THE AMERICAN MEDICAL ASSOCIATION APRIL 15, 1949

Prepayment Medical Care

The rapid and orderly growth of voluntary prepayment medical and hospital care plans has been one of the striking and stimulating economic developments supported by American medicine during the past fifteen years. The initiating and propelling force of these plans was the medical profession acting

through its local and state societies and later its national organization. This movement has attained national proportions. At the present time over 30,000,000 people are covered by Blue Cross type hospital insurance and over 10,000,000 by Blue Shield type medical care insurance. This stimulus and the accumulated experience gained by these organizations have prompted many private insurance companies to enter this field, and they are making substantial contributions toward the accomplishment of our ultimate objective, namely—voluntary health insurance at a nominal cost for all the people in the United States. The total number of persons covered by all voluntary agencies is 55,000,000 for hospitalization and 37,000,000 for surgical or medical care.

The American Medical Association is not engaged in the insurance business and has no intention of giving a preferential standing to any one type of voluntary plan. The American Medical Association does believe, however, that it has a definite function to perform, that of evaluating any insurance plan presented to the people, thus protecting them as far as possible against unscrupulous or unsound plans. The American Medical Association further believes that the people should be free to purchase the type of health security they desire. To this end the Council on Medical Service has for the past four years critically examined various plans and has given its approval to numerous plans operating on a local or state basis. The Council has felt the need for a national organization which would act as a trade and coordinating agency for all medically sponsored plans.

We therefore recommend:

(1) The formation of a national coordinating agency representing all qualified voluntary prepayment plans in accordance with the proposal made to the Board of Trustees by the Council on Medical Service, February 10, 1949.

(2) That there shall be no official connection between the American Medical Association and the Associated Medical Care Plans. However, the American Medical Association will continue to approve or disapprove all voluntary medical care plans.

(3) The recognition of AMCP as a trade organization of member plans and Blue Cross as occupying a similar position for voluntary prepayment hospital care plans.

(4) The recognition of the responsibility of the American Medical Association to

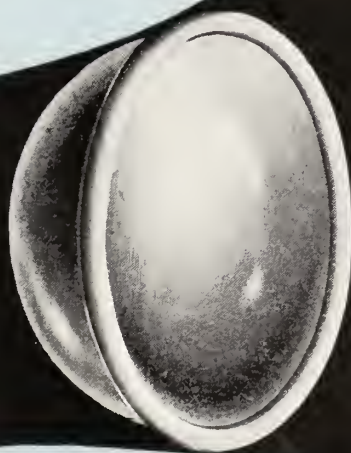
(A) Promote the principle of voluntary insurance by educating the people as to their need for such coverage and by obtaining full cooperation from state and county medical organizations in the local field.

(B) Inform the American people of the availability of approved plans that propose to supply on a prepayment basis security against the economic hazards of serious illness.

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YOUNG DOCTORS LEARN OF COUNTRY PRACTICE

A recent account of the manner in which the Illinois State Medical Society has attempted to interest young doctors of 1949 in the thrill of country practice, might well be followed by other medical societies.

According to a release issued April 19th by the Illinois organization, 75 young interns and residents just about ready to begin their practice, were invited to the Hotel LaSalle, Chicago, as dinner guests of the Society on April 26th. There, they were told the story of the advantages which the small town has to offer over the big city, to a young doctor.

Three veteran small-town doctors explained to them how to set up an office, how to handle patients in home and office visits, and methods of meeting other problems of practice.

A young doctor recently out on his own in a country town, told of his problems and how they had been solved with the help of neighbors.

A small-town banker was on the program to describe how to find and finance equipment, offices, homes and cars.

A description of 40 Illinois rural areas in need of additional physicians was given the young doctors, with the names and addresses of key persons from whom they might obtain information and advice. A second list of 30 Illinois country doctors who would like to retire and were looking for young men to take their places, was also provided.

"There is a place waiting for every one of these lads in downstate Illinois," it was explained by Harlan English, M.D., of Danville, chairman of the Society's Committee on Rural Medical Service, who conceived the plan.

"We believe that, if the personal and professional satisfactions of country general practice are presented to them by men who can answer all their questions, many of them will elect to settle in these areas of need.

"All these young men are completing residencies or internships in medical schools or hospitals of Chicago. All came originally from small towns and would adjust themselves to life there more readily than city-bred boys. We believe they would all be better off in small towns anyway. But we have found that the medical schools do not explain to them the problems of rural practice. This meeting is planned to meet that deficiency."

The Illinois State Medical Society, among other efforts to increase the number of physicians in rural areas, a year ago established a \$100,000 joint student loan fund in collaboration with the Illinois Agricultural Association. Funds are loaned from it to students to pay for their medical education.

SOCIAL SECURITY COSTS ESTIMATED

Non-government tax specialists figure that the added costs of President Truman's social security program, including health insurance, would be 5% of payroll on the first \$4,800 of wages or salary annually. This does not include a possible increase in the unemployment compensation tax rates. The specialists analyze the cost of administration proposals as follows:

OASI tax increase from 1% to 1½%; health and medical care .25% graduated to 2%; temporary disability .5%; permanent disability 1%. Total tax on employer and employee, each, 3½%, graduated to 5%.

NEWS ITEMS

Dr. Patricia A. Carter of Charleston, announces the association of Dr. Thomas G. Herbert, Jr. in the practice of obstetrics and gynecology.

Dr. Clay W. Evatt has announced the association of Dr. David R. Stack, Jr. in the practice of ophthalmology, otolaryngology and maxillofacial surgery. Their offices are located at 91 Rutledge Avenue, Charleston.

Dr. Katherine Baylis MacInnis of Columbia attended the annual meeting of the American College of Allergists in Chicago in April. Dr. MacInnis was the first woman to be elected to the Board of Regents of the American College of Allergists for a term of two years.

Dr. William R. DeLoache has opened offices in Greenville for the practice of pediatrics.

Dr. James P. Ravenel of Charleston was installed as

President of the Southeastern section of the American Urological Association at the meeting held in Florida in March.

Dr. and Mrs. Grover C. Sheppard of Fort Mill have announced the association of Grover Cleveland Sheppard, III (Chippey), in the general practice of living. Chippey was born March 26, 1949, at a hospital in Charlotte.

The Cook County Graduate School of Medicine of Chicago has arranged two courses that will be of special interest to some of the Members of the South Carolina Medical Society. A Two Weeks' Intensive Personal Course in the "Diagnosis and Treatment of Congenital Malformations of the Heart" will be offered by Benjamin M. Gasul, M. D. starting Monday, June 13. A Two Weeks' Intensive Personal Course in "Cerebral Palsy" will be offered by M. A. Perlestein, M. D. starting Monday, August 1. These physicians are Members of the Attending Staff of the Cook County Hospital.



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BIBLIOGRAPHY: 1. Brown, E. A.: Ann. Allergy 6:393, 1948. 2. Wittich, F. W.: Ann. Allergy 6:497, 1948.

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Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT NO. 630

HISTORY: A 75 year old white man admitted to hospital on Feb. 24, with vague and indefinite history. Approximately six months before admission he noticed an increasing generalized weakness. For the past three months he has had frequent generalized abdominal pains, has often vomited, and was usually constipated. He has never noted blood in vomitus or stools. He has been able to take only small amounts of soft food and liquid because of nausea and vomiting and for last two months has only had water, milk, and soup. He has been confined to bed since before Christmas. He told one examiner that his bowel movements had been intermittent stating, "I had nothing to pass." Stools are small and milky looking. During the preceding summer he said that he experienced excessive gain in weight, reaching the weight of about 200 lbs. Since that time he has lost about 50 lbs.

Review of symptoms reveals no other definite findings. He denied having had dyspnea, orthopnea, palpitation, or pain in epicardial or substernal region.

PHYSICAL EXAMINATION: T 99.4, P 120, R 28, BP 148/90. Aged white man who has marked abdominal distension. Skin turgor was poor and there was evidence of weight loss. Neck not stiff, no venous distension. Symmetrical and equal expansion of chest, and lungs clear to percussion and auscultation. Heart questionably enlarged to left. PMI diffuse. Rhythm regular, no murmurs. Mild to medium sclerotic of radial artery. Abdomen markedly distended and tympanitic. No areas of tenderness or masses, but abdominal wall is tight. There was 1 to 2 plus edema of the legs with questionable sacral edema.

LABORATORY DATA: 2/24: Urinalysis Sp. Gr. 1.014, WBC 10 to 12 HPF; RBC 0 to 1/HPF. On the same date blood count RBC 3,750,000, WBC 6,800; Hemoglobin 11 gms. PMN 74%.

2/24: Gastric analysis gross and occult blood positive. Free acid none, lactic acid none, combined acid 7 units. On 2/26 venous pressure 85 mm. water, circulation time arm-to-tongue with magnesium sulphate 28 seconds. On 2/25—EKG: LVP. Flattening of T waves all leads. X-rays of chest and abdomen available.

COURSE: A Miller-Abbott tube was passed and on 2/26 a sigmoidoscopy was performed. Scope passed without trouble to 19 cm. level where lumen suddenly ended and catheter could not be passed further. Patient stated on the same day that he was passing small amounts of flatus per rectum. Enema returned clear, but patient could not retain 1000 cc. at one time. On 2/27 cecostomy performed. Movable mass present in sigmoid. No metastases found. On 2/28 condition poor. Color ashen and abdomen somewhat

distended. Later in the morning patient suddenly became cyanotic. No pulse felt, heart sounds barely audible. He was pronounced dead at 10:25 A. M. on Feb. 28.

Dr. F. E. Kredel conducting.

Dr. Kredel: Mr. Zemp, please give up your diagnosis and how you arrived at it.

Student Zemp: My first choice was carcinoma of the sigmoid colon. All the clinical facts point to a chronic form of intestinal obstruction. In a patient of this age having nausea and vomiting, weight loss, constipation, and evidence of an obstruction in the lower bowel, the first process that I would think about is carcinoma. The obstruction has been partial or intermittently complete. Vomiting is not common in obstruction of the large intestine, particularly if it is of the left side of the colon. Incompetency of the ileo-cecal valve, however, may allow accumulated gas and fluid to pass into the small intestine or the vomiting may be a reflex phenomenon even when the ileocecal valve does not allow retrograde passage of material. The absence of any clinical evidence of metastases is also fitting to carcinoma of the sigmoid colon as they generally remain localized for a considerable period of time and metastasize relatively late in the course of the disease.

The venous pressure is within normal limits and although the circulation time is increased, I do not believe this to be of any special significance. The fact that he has lived for 75 years seems to indicate that he had a pretty good heart.

Dr. Kredel: What do you think was the cause of death?

Student Zemp: I believe pulmonary embolism the most likely. A patient of this age who has been confined to bed very frequently develops thrombosis of the venous channels in the pelvis or lower extremities. These thrombi may have to some extent been released by the decompression effected by the Miller-Abbott tube. Lessening of intra-abdominal pressure would relieve this compression and allow clots to be freed into the circulation.

Dr. Kredel: What do you think of the gastric findings?

Student Zemp: I do not consider them significant. Although gastric carcinoma could be present with such findings, I do not think that was the case here. It is not unusual for people of this age to have no free acid and I think that blood could result from trauma secondary passage of the Levine tube.

Dr. Kredel: Mr. Timmons, do you agree with what has been said?

Student Timmons: I made the same diagnosis and thought the pulmonary embolism was the likely cause of death. I think there are other causes that should be

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From where I sit
by Joe Marsh

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Duke Thomas bought a farm with the money he'd saved in the Service, but he couldn't get a tractor. He needed it badly, but was tenth on the local dealer's list.

"Tell you what," old man Peters says. "If those nine fellows ahead of you agree, you'll get the next one I get in." "No, thanks," says Duke, "I'll just take my turn."

But old Peters mails out nine postcards. And the other day he tells Duke his tractor will be in next week. "I simply wrote the facts to the fellows ahead of you. They decided it."

From where I sit, it's that spirit of understanding that helps make our democracy so great. Understanding for the other fellow's problems and respect for the other fellow's rights—whether it's his right to earn a living, his right to cast his vote against your candidate, or even his right to enjoy a moderate, friendly glass of beer or ale—if and when he chooses. Let's always keep it that way!

Joe Marsh

mentioned such as diverticulitis, partial or intermittent volvulus, and polyposis. Diverticulitis is not uncommon and could produce this picture. Any inflammatory lesion in this area might bring about bowel obstruction.

Dr. Kredel: What is the usual symptom of Polyposis?

Student Timmons: Bloody stools is the most common symptom so that this would be unlikely in this case. I also considered carcinoma of the stomach and tried to explain the whole situation on this. Gastric carcinoma can produce metastases to the pelvic peritoneum, infiltrate various structures in this area and produce obstruction. I still feel that carcinoma of the sigmoid colon is more likely however.

Dr. Kredel: Does any other student wish to contribute?

Student King: I think the edema of the lower extremities and sacrum in this case is probably due to hypoproteinemia rather than from cardiac failure. The T wave changes are not too significant. They probably indicate some degree of myocardial damage, but these could conceivably be brought about by malnutrition and avitaminosis.

The pyuria is likely to be due to some degree of prostatic obstruction with resultant infection.

Student Larrick: I think it would be possible for this man to have obstruction higher in the intestinal tract which would still be related to a primary carcinoma of the sigmoid colon. Peritoneal metastases could take place and an implant on the surface of the small intestine could penetrate the wall and produce obstruction or cause kinking of the bowel. It seems to me that there is too much vomiting and abdominal distention for obstruction in the lower end of the colon alone.

Final Pathological Diagnosis:

Dr. Pratt-Thomas: Diverticulosis and Diverticulitis of Colon with Intestinal Obstruction. Coronary Arterios-

clerosis with Thrombosis and Infarction of Myocardium. The outstanding feature in the abdominal cavity was a grossly distended colon which obscured the other viscera. The descending transverse and ascending colon were distended by gas and soft foamy feces so as to measure 14 cms. in diameter. In the sigmoid colon there was a firm indurated area measuring 8 cms. in length and 4 cms. in diameter. In this segment of the intestine the mucosal surface was markedly distorted being thickened and furrowed and on cross section of the bowel wall numerous diverticuli were noted some being filled with firm fecal concretions. Microscopic examination showed acute and chronic inflammatory changes of many of these diverticuli. In the dilated colon above the site of obstruction there were numerous irregular ulcerations of the mucosa measuring up to 2½ cms. in diameter. These ulcers ramified and showed interconnections beneath intact mucosa. They represent the so-called sterocul ulcers which are seen in cases of long standing obstruction and are produced by impaired blood supply together with a traumatizing action of impacted fecal masses. Adherent to the colon at the site of the obstructing diverticulitis was a loop of ileum which contained a small perforation with related minimal peritonitis. This is the type of event that Mr. Larrick mentioned which could produce obstruction of the intestine at two sites, although there is no evidence that this was an obstructing feature here.

This man also had severe arteriosclerosis and this was responsible for his death. The circumflex branch of the left coronary artery was occluded by thrombus and the superior antero-lateral portion of the left ventricle showed grayish-yellow mottling. Microscopically there was extensive acute necrosis of the myocardium as well as older areas showing evidence of healing. The aorta also showed a severe arteriosclerotic process with areas of ulceration, mural thrombosis, and aneurysmal dilatation of the arch.

DEATHS

Alexander Moultrie Brailsford

Dr. A. M. Brailsford, 78, died in the Shaw Field Hospital on April 6, following a collapse while driving to attend the funeral of a cousin.

A native of Clarendon County, Dr. Brailsford received his medical education at the Medical College of S. C. (Class of 1897). Following practice at Mullins for a period of years he took postgraduate work in New York and New Orleans. Prior to World War I he entered the army and served as medical officer until he was retired for physical disability in 1934. During World War II he was active in Red Cross work.

Dr. Brailsford was keenly interested in medical organizations. He was an Honorary member of the S. C. Medical Association and the oldest living President of the Pee Dee Medical Society. During his life he served as a member of the State Board of Medical Examiners, as surgeon of the Atlantic Coast Line Railroad and was Chief Surgeon for the S. C. National Guard. He was the author of three books dealing with medicine.

Dr. Brailsford is survived by his widow, the former Miss Maud Cunyus of San Antonio, Texas.

Cecil Rigby

Dr. Cecil Rigby, 58, died suddenly at his home in Spartanburg on March 26.

A native of Dorchester County, Dr. Rigby received his education at The Citadel (Class of 1912) and the University of Maryland (1916). Following this he served for three years on the staff of the Hospital for Women in Baltimore and also spent two seasons in Europe doing postgraduate study.

Returning to his native state, Dr. Rigby opened his office for the practice of surgery in Spartanburg, with particular emphasis on obstetrics and gynecology. He soon established a wide reputation in his chosen field. He was a Fellow of the American College of Surgeons and of the Southeastern Surgical Congress. He also served as President of the Spartanburg County Medical Society.

Dr. Rigby is survived by his widow, Dr. Hallie Clark Rigby, who was associated with him in practice.



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ABSTRACTS

ABSTRACTS

Gurd, F. B.: Twenty-Five Easy Ways of Getting Into Trouble in the Care of Fractures.

The Am. Jour. of Surg., 76: 506-514.

November 1948.

The author feels that, if the twenty-five errors listed below are avoided, the results obtained in the treatment of fractures will be improved.

Errors made before treatment of the fracture are (1) failure to assess the severity of associated traumatic shock, (2) failure to diagnose concealed non-bony injuries, (3) failure to diagnose all concomitant fractures, (4) failure to obtain adequate preoperative x-ray films, (5) failure to identify films, (6) failure to interpret x-ray photographs, (7) failure to recognize the mechanism of production of the injury, (8) failure to keep adequate records such as the initial recording of primary injury to vessels and nerves, (9) failure to notify all concerned of the prognosis.

Errors made during the actual treatment of fractures are (10) delay in fixation, (11) delay in reduction, (12) inadequate reduction, (13) undue roughness during reduction, (14) repeated attempts at reduction which the author believes to be the most important cause of bone atrophy, (15) excessive padding under plaster, (16) technical errors during open operation resulting in infection, gangrene or skin loss, (17) delay in operating compound fractures, inadequate operation and overconfidence in bacteriostatic drugs.

Errors made during the healing period of the fracture are (18) failure to maintain close observation during healing, (19) failure to check maintenance of reduction by x-ray films, (20) maintenance of the limb in a non-physiologic position, (21) application of unpadded plaster while edema is present, (22) failure to instruct in the use of appliances, (23) too early mobilization or too early weight-bearing, (24) delay in rehabilitation, (25) too early and ill-conceived physiotherapy.

Cross, J. E., Guralnick, E., Daland, E. M.:

Carcinoma of the Lip, Surg., Gynec., Obst. 87:153

August 1948

Carcinoma of the lip, one of the most malignant neoplasms of the oral cavity, is said to be one of the most readily curable malignancies encountered.

The authors review 563 cases with carcinoma of the lip. An analysis showed the disorder to occur predominantly in males (98%) with a mean age of 62 years who smoked pipes and who had poor dental care.

Surgery as a choice of treatment was preferred to radiation; however, in selected cases a combination of the two or radiation alone was used. The operative procedure was directed toward complete excision of

the lesion, using plastic surgery repair when necessary and carrying out radical neck dissection as a second stage when indicated.

The cases are divided into smaller groups in regard to types of lesions, treatment, etc. to facilitate detailed observation. Suffice it to say the total cure rate irrespective of the type of lesion or treatment was 67.1%, based on the 3 year cure, and 63.6%, based on the 5 year cure.

It was found that 91.8% of patients with primary carcinoma treated by surgery alone survived 5 years or longer; whereas, a similar group treated with radiation alone gave 5 year cures in 76%. The curability was directly related to the size of the lesion, the pathological grade of the tumor, the presence or absence of lymph node metastasis and the location of the lesion on the lip. Carcinomas of the labial commissures were twice as difficult to control as tumors elsewhere on the lip. The cure rate for patients with pathologically proved cervical node metastasis who underwent neck dissection was 35.9%.

Ravitch, M. M. and McCune, M., Jr.: Reduction of Intussusception by Barium Enema. An. of Surg. 128: 904-917. November 1948.

The authors present a short history of the management of intussusception which points out that the disease has a far lower mortality when treated primarily by hydrostatic pressure than when treated primarily by operation.

Their barium technic used in a series of 27 cases in which 79% had complete reduction is as follows: under fluoroscopy, without anesthesia, a 20-40 cc unlubricated Foley bag catheter is inserted in the rectum and barium is permitted to run in from a height of three feet. The barium outlines the intussusception producing a concave meniscus. When the intussusception gives ground the meniscus flattens out. After three unsuccessful attempts, operation is performed.

A successful reduction is denoted by the following criteria: (1) barium in the small bowel, (2) the return of barium with feces or flatus, (3) the mass no longer palpable, (4) clinical relief, (5) the appearance of charcoal given by mouth or a blood-free stool. Diarrhea and even dysentery are not rare occurrences after any type of reduction. Occasionally operation is required to complete the reduction.

The diagnosis of intussusception by fluoroscopy is fairly simple. If there is any doubt as to complete reduction, momentary inspection of the terminal ileum and cecum may be made through a McBurney incision. The rate of recurrence is about 2%. The incidence of tumor in children causing intussusception is 2.5%. Rupture of the bowel with three feet of pressure is rare. The entire procedure from start to finish takes only half an hour.

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WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

The members of the South Carolina Obstetrical and Gynecological Society, their wives and special guests were delightfully entertained at the third annual meeting held in Columbia, April 10 and 11.

Sunday evening Dr. and Mrs. Manly E. Hutchinson gave a drop-in party at their home on Monroe Street. An automobile tour of gardens and points of historical interest was arranged for Monday afternoon by the Columbia group for the out-of-town women. During the afternoon Mrs. W. A. Hart was hostess at a lovely tea at her home on Tanglewood Road. Mrs. F. B. C. Geibel and Mrs. Herbert Black honored the doctors'

wives with a supper party at the Green Derby on Monday evening.

The wives who were entertained Monday included Mrs. David Watson, Mrs. J. Decherd Guess, Mrs. Robert Dacus and Mrs. Joseph Converse, all of Greenville; Mrs. William Thurmond, Mrs. J. T. Purcell, Augusta, Ga.; Mrs. W. J. Snyder, Sumter; Mrs. Herbert Blake, Anderson; Mrs. John Fleming, Spartanburg; Mrs. Henry de Saussure, Charleston; Mrs. Hartwell Boyd, Atlanta, Ga.; Mrs. L. P. Fouche, Mrs. F. B. C. Geibel, Mrs. Herbert Glack, Mrs. Robert Seibels, Mrs. W. A. Hart and Mrs. Manly Hutchinson of Columbia.

The following members of the Association have paid the A. M. A. Assessment of \$25.00
during the past month (March 20—April 20).

ANDERSON
Blake, Herbert
Pruitt, Samuel O.
Sanders, James O.
BELTON
Haynie, James W.
CAYCE
Lattimer, R. C.
CENTRAL
Bearden, James D.
CHARLESTON
Baker, Robt. J.
Beach, M. W.
Beckman, John C.
Cannon, J. H.
Chamberlain, O. B.
Cleckley, Jas. J.
DeSaussure, H. W.
Evatt, Clay W.
Hipsh, Edw.
Kredel, Frederick E.
Mood, Geo. McF., Jr.
Paul, J. R., Jr.
Pickett, O. M.
Reynolds, T. W.
Rhett, Wm. P.
Richards, G. P.
Scott, James E.
Steinberg, Matthew
Wilson, I. Ripon, Sr.
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CLINTON
Rhame, D. O.
Sullivan, E. N.
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Abel, T. D.
Barron, W. T.
Benet, George
Boone, James E.
Bridgers, W. H.
Bunch, G. H., Jr.
Dove, Herbert R.

Durham, Robt. B.
Freed, Joe E.
Geiger, F. L.
Guyton, C. L.
Josey, R. B.
Pitts, T. A.
Seastrunk, J. G.
Shealy, Kirby D.
Talbert, S. W.
Timmons, Jas. M.
Wallace, John
Wilson, Harry F.
Wyman, Hugh E.
CONWAY
Borop, Niles A.
Smith, R. C.
Gilland, J. D., Jr.
DARLINGTON
Coleman, M. J.
EDGEFIELD
Dunnivant, R. B.
Nicholson, A. R.
Nicholson, Geo. B.
FLORENCE
Allen, E. M., Jr.
Allen, James
Floyd, L. C., Jr.
Hay, P. D., Jr.
Herbert, Henry W.
Hunter, J. F. C.
Kingsbury, C. H.
Lide, L. M.
McMeans, J. W.
GREENVILLE
Corn, Charles P.
Pollitzer, R. M.
Reese, David P.
Thames, Wm. H.
Whitworth, H. M.
Wilson, David A.
GREENWOOD
Adams, A. E.
Alston, W. C., Jr.
Bell, John W.

Scurry, C. J.
KINGSTREE
Hemingway, T. S.
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Timmons, T. A.
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LEXINGTON
Liverman, J. S.
NINETY SIX
Schneider, L. S.
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Jenkins, Wm. J.
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Training Of The Young Doctor

ROBERT B. DURHAM, M. D.
Columbia, S. C.

The subject which I am going to discuss is not a popular one, although one to which I have given careful thought for many years. It seems to me that some changes affecting the curriculum of medical schools could be worked out whereby some of the unnecessary or unessential subjects could be eliminated from the medical courses. Since we have added twelve grades to our school systems, thereby giving the pupil at least the equivalent of freshman work at college, his pre-medical courses could be shortened somewhere along the line in the course of his training; in high school, pre-medical studies or in medical schools. The young adolescent medical student is as ready for hard intellectual work as for anything else. There are many young men who would like to take up medicine as a profession but when faced with the staggering fact that it takes them twelve years before they can hang up their shingles, it is small wonder they choose some other profession.

Dr. R. B. Davis, of Greensboro, North Carolina has said: "It is hoped that some medical schools, somewhere, will launch out upon a practical medical educational program which will take the boys from the high school and enter them into a medical curriculum of six years, teaching English, public speaking, anatomy, physiology, pathology and pharmacology and including within these six years sufficient actual practical experience so that any who is willing to work and who has the determination to be a good doctor, can obtain his M. D. degree and his license to practice general medicine at the age of 24."

In the event a young doctor wishes to specialize, his years of training are further added to by the various Boards.

I am quite sure that 98% of our young doctors, graduating from medical college, successfully passing their State Medical Examinations and obtaining their licenses, would not attempt any procedure they felt

they were not capable of handling, but if the various Boards continue to add on years of training, as they have in the past fifteen years—a man or woman will have reached the age of thirty-four or thirty-five before they are considered competent; or before they can begin making a livelihood. Many of our hospitals today have what is generally termed a "Closed Staff." You have to be a member of the Obstretical Board before you can deliver a baby in the institution. You have to be a member of the Board of Physicians before you can treat pneumonia or any other disease; or a member of the Surgical Board before you can lance an abscess or take out an appendix. It seems to me that this is a grave injustice to the young doctors who have devoted years of study to the art of healing. If this trend continues it will mean the passing out of existence of the *GREAT* general practitioner.

I would like at this point to quote from Dr. Thomas H. Lanman's Presidential address before the New England Surgical Society, Providence, Rhode Island, October 3, 1947. Dr. Lanman is professor of surgery at the Harvard Medical School. "I believe that the rules of the American Board of Surgery must be made more flexible and that they should be influenced by the sound and collective opinion of the members of this society. We should furnish our representatives on the various Boards with a clearer picture of the varying needs in the various communities." Already, conditions are quite different as far as the surgical training program is concerned from what they were when the Board of Surgery was organized. The war and its political sequelae have disrupted surgical training to a considerable degree. It is certain that the minimum requirements before a candidate can be certified by the American Board of Surgery are sound in principle but I believe there is need for a greater flexibility in their application. How many of our members meet the present requirements of the American Board of Surgery, as far as their formal training in length of internships and residencies is concerned? I know that I do not.

In his address as President of the American Ortho-

* Presidential Address delivered at Annual Session, S. C. Med. Assoc., May 18, 1949.

pedic Society, in June, 1946, Dr. J. Albert Key, of St. Louis, stated: "Due to the unswerving devotion to duty of the Membership Committees, our American Orthopedic Association comprises a group of orthopedic surgeons whose ability cannot be questioned; and yet, I doubt if ten percent of our present membership could meet the present training requirements. It is thus evident that it must be possible for one to become proficient in orthopedic surgery by other routes. I wonder if we are not making a grave mistake in our attempt to regiment the training of orthopedic surgery. To limit future orthopedic surgeons to those of our young medical graduates who can be forced into a mold is to exclude many whose qualifications justly entitle them to certification and whose abilities as orthopedic surgeons would be of great value.

"As the ward beds are encroached on by private and semi-private cases, there will be fewer and fewer cases under the care of the house staff. Coincidentally, and stimulated by the requirements of the American College of Surgeons and American Board of Surgery, more and more men desire a longer training period. Thus, the problem of adequate training for the young surgeon becomes increasingly difficult. No one will deny that increased training is a desirable thing, but where are the beds to train so many for so long? That would be difficult to answer in any event, but with the increasing shortage of ward beds it will become even more so. The answer to these questions must be forthcoming soon."

As this young correspondent points out, the so-called "Ward-beds" in the teaching hospitals are becoming fewer because of certain insurance plans, such as, the Blue Cross, as well as other factors. As a result, the opportunities for the proper surgical training of residents—particularly the actual operative work done by the house staff—are proportionately poorer. In passing, it is rather interesting to note his phraseology, "ward beds are *ENCROACHED* on by private cases."

I would like to quote from an article by the late Dr. Elliott C. Cutler, Professor of Surgery, Harvard University: "Twenty years ago a great many of our largest hospitals had a major number of so-called charity or free beds frequented by the poorer class where such people who could not afford the services of a private surgeon went to have their surgery performed. The teachers of surgery in the great schools were very jealous of their prerogatives as regards these "open" or charity beds because this was the material which they could utilize as they saw best in the final education of the young surgeon.

"The education of the surgeon and the physician differ essentially in that although many may profit from the examination of a patient with a cardiac murmur or some unusual medical sign, only the person who himself conducts the operative procedure can fully benefit from that experience. This handicraft

aspect of surgery is something that must be learned and it must be learned under the most careful tutelage. After several years as an intern or assistant resident surgeon or fellow, the young surgeon reaches the point where he can not progress further unless he has individual surgical responsibility and the opportunity to operate independently and by himself. The experience acquired by such operations gives to the young surgeon confidence and practice which are essential to his final development.

"Shifting economic trends now are jeopardizing the existence of so-called charity or "open" beds in many of our greatest hospitals, either because the people are in large part becoming insured through group insurance systems, or because industry is taking over the care of its laborers and has its own doctors to look after them. Such patients are now private patients in the sense that a contract exists which places them under the care of specific individuals and their surgical care cannot be turned over to other than those mentioned in the contract. The number of "open" or charity beds is further diminished by the rising income of all workers which has now reached the level at which most hospitals could fill a greater percentage of their beds with paying patients."

In my humble opinion, after our young doctors finish medical school, pass the State Board of Medical Examiners, and take one year internship, they are qualified to begin the practice of medicine. If they intend to specialize they can associate themselves with a man in any of the various specialties, and work with him over a period of—say five to ten years—before he begins any of the various specialties alone. In this way, I think, we can produce much more competent surgeons, obstetricians, internists, urologists and so forth, for in this way, and this way alone, by getting their own hands into the work, and guided by those who have had vast experience they are far better trained than spending three to five years in a hospital as residents doing histories, physicals and general hospital routines.

These young doctors, at the same time, could be serving in a capacity that would be of vast help, not only to them in obtaining knowledge and experience, but could do much toward winning back the confidence and respect of the lay generally. From all quarters comes the same hue and cry "we cannot get a doctor at night." The public is being neglected as far as medical services are concerned. The young doctor is not to blame, the fault lies with us older men and the inflexible rules of our various Boards. Seventy-five percent of the young doctor's time must be devoted to his specialty. Small wonder Socialized or Federal Medicine is being forced upon us.

In 1910, with a population of ninety-two million in the United States, there were one hundred thirty-one medical schools; graduating four thousand four hundred students. In 1940, with a population of one hundred thirty-one million, there were seventy-seven

medical schools; graduating five thousand ninety-seven students. In these thirty years there has been a decrease of fifty-four medical schools, probably because they were classed as "B" or "C" schools; however, our profession has not made the "A" schools adequate to graduate enough medical students to serve the thirty-nine million increased population. An increase of only one thousand one hundred forty-three doctors in the same period of time!

We, as doctors, have failed in our duties.

As I see it—our Boards are laying too much stress on students with "A" grades in pre-medical work, and not enough on the aptitude of the individual. Far be it from me to take any credit away from "A" grade students, but so often this class, upon graduation, prefers science, chemistry, professorships or some highly scientific branch of medicine, rather than the practice of general medicine in rural communities, where the need is so urgent. The less skilled students

in books, may actually make a finer doctor in practice than the Magna Cum Laude graduates. The answers to these questions must be forthcoming,—and soon.

Let us then meet at the fence, where the boundaries join, work out a solution which will be advantageous to all persons concerned, defeat Socialized Medicine, and reclaim the admiration and respect of the communities to which we belong.

REFERENCES

1. R. B. Davis, M. D.; *Current Medical Digest*, August 1948.
2. Thomas H. Lanman, M. D.; *Presidential Address—The New England Journal of Medicine*, April 8, 1948.
3. Elliott C. Cutler, M. D.; *The American Journal of Surgery*, June 1948.
4. *The State*; March 1949.

Multiple Myeloma

HUGH SMITH, JR., M. D.

Resident in Medicine

Joseph H. Pratt Diagnostic Hospital
Boston, Massachusetts

Although uncommon, multiple myeloma is not rare. Seven cases have been diagnosed at this hospital from the last 7,000 admissions. The diagnosis should be considered in any patient complaining of various bone pains, especially if he is anemic, shows evidence of renal damage, and has an extremely rapid sedimentation rate. Often the diagnosis can be made from simple laboratory tests that can be performed easily by any physician.

Recognition of the disease is important in order to be able to prognosticate correctly and to treat the patient wisely. Sometimes absolute proof of the diagnosis may be difficult although this is not usually true. The following brief report serves to illustrate a fairly typical case, but yet with negative tests for Bence-Jones protein in the urine and with three negative bone marrow aspirations.

CASE REPORT

A 61 year old varnish maker was first seen in the Clinic Consultation Service of the Joseph H. Pratt Diagnostic Hospital on March 30, 1949, with complaints of pain in the region of the left knee and right elbow for the previous two months. He stated that he was well until two years ago, when he noted the appearance of a tumor on his chest. This enlarged steadily for a month. After consultation, an X-ray diagnosis of giant cell tumor of the manubrium of the sternum was made and roentgen treatments were given with partial regression in size of the tumor.

Following this, he got along fairly well until he fractured a rib while lifting a five gallon can of shellac. A year prior to admission, slight trauma led to a fracture of the 1 ft radius through a "bone cyst." This healed promptly. One month prior to admission he developed "bronchopneumonia." After recovery, he complained of moderate shortness of breath and pain in the left knee and right elbow. Films showed cystic areas in many bones and fluid in both pleural cavities, and so he was referred to this Clinic for study. He had lost 15 pounds in weight during the last two months prior to admission.

Prior to the present illness he had always been well except for malaria at the age of ten years, and an appendectomy at 44. He had worked for 29 years mixing shellacs and varnishes, working in high concentrations of alcohol and lead fumes.

Physical examination revealed a well developed, well nourished white man who did not appear ill. His temperature was 98.6 degrees F., pulse 90, respirations 20, blood pressure 180/100 mm. Hg., and vital capacity 3,200 cc. He had a hard, non-tender mass over the sternal manubrium about 10 cm. in diameter and 3 cm. deep, (Figure 1) and several smaller tumors involving various ribs laterally and posteriorly. A soft, blowing, systolic, aortic murmur was heard but no thrill was palpable. There was limitation of motion in the left knee and tenderness to firm pressure over the femur above the knee. Otherwise a complete



Figure 1.—Two views showing the tumor at the upper end of the sternum.

physical examination was within normal limits.

Laboratory studies revealed a blood sedimentation rate of 110 mm. per hour, 11.0 grams (70%) hemoglobin, 3,780,000 red blood cells per cu. mm., 4,750 white blood cells, with 55% polymorphonuclear leukocytes, 41% lymphocytes, 2% monocytes and 2% eosinophiles. There were 315,000 platelets per cu. mm., and 0.8% reticulocytes. There was a strong tendency to rouleaux formation noted on the smear. Urinalysis revealed albuminuria, a few red blood cells, a few white blood cells, and casts. However, the NPN was only 30 mg. percent. There was no Bence-Jones proteinuria. Serologic tests for syphilis were negative. Serum calcium, phosphorus, and alkaline phosphatase were within normal limits. The cholesterol was 104 mg. percent. His total serum proteins were 10.8 grams percent with 2.1 grams of albumin and 8.7 grams of globulin. Electrocardiograms were normal. X-rays revealed "numerous areas of destruction in the ribs, pubic bone, lower end of the left femur. There are numerous osteolytic round lesions varying in size in the right humerus, the lower end of the right femur and the skull. There is also destruction of the second lumbar vertebra."

Aspiration of the sternal tumor and of another area of the sternum revealed acellular marrow. Aspiration of the vertebral spinous process showed a hypocellular marrow. No myeloma cells could be found. Finally, surgical biopsy of a rib nodule revealed the typical picture of multiple myeloma, plasma cell type.

This case illustrates most of the usual clinical features of multiple myeloma. The disease is found in

men twice as often as in women, and most commonly in the ages from 40 to 60, although it may occur at any age. There is no racial variation.

Multiple myeloma is a progressively wasting disease, but the diagnosis can usually be made before the wasting becomes obvious. Often the first symptom is pain, which may not be severe. This pain originates in the bone involved by growth of the myeloma cells. Often the painful area is near a joint and may cause a mistaken diagnosis of arthritis. There may be a fracture, following slight trauma, and X-rays, if showing a solitary cystic lesion, may be interpreted as evidence of a pathological fracture through a benign bone cyst or giant cell tumor.

In other cases a tumor growing in the sternum, rib, or skull may appear as the first evidence of myeloma. These tumors are highly vascular and are often soft, and may pulsate. Multiple nodules may appear later. When in the vertebrae, they may lead to painful skeletal deformities and various neurological abnormalities, of which paraplegia is the most common. The myeloma nodules may grow in the testes. Sometimes their growth from the ribs into the chest leads to hydrothorax, fibrinous or sanguinofibrinous pleurisy, in one or both pleural cavities. Microscopic examination of the aspirated effusion may lead to the diagnosis.

The kidneys are usually involved and may lead to uremia.¹ In fact, uremia without significant hypertension should strongly suggest the diagnoses of multiple myeloma, amyloidosis, or hypervitaminosis D.

Infrequently the liver or other organs may be involved.²

Laboratory studies nearly always reveal anemia, which is normochromic or hypochromic, and progressive. The erythrocyte sedimentation rate is frequently very rapid, often above 100 mm. per hour. There is elevation of the total serum proteins in about 50% of the cases. This is due to hyperglobulinemia, and may be extreme. Sometimes when the total protein value is normal, fractionation studies will reveal that there is still hyperglobulinemia but with hypoalbuminemia which keeps the total value from being elevated. Associated with the hyperglobulinemia, there is marked tendency for the erythrocytes to form rouleaux. This contributes to the rapid sedimentation rate. It is also easily seen on the slide stained for the differential white cell count. If extreme, it may interfere with the counting of the red blood cells in the counting chamber.

Bence-Jones protein is found in the urine in over one-half the cases. It has been intensively studied but the exact constitution and origin are still obscure. It is apparently a group of proteins of low molecular weight (35,000 to 37,000).^{1, 3} It is not entirely specific for multiple myeloma, being rarely found in leukemia, osteomyelitis, bone tumors, and polycythemia,⁴ but is a great diagnostic aid when present. Bence-Jones protein coagulates between 48 to 58 degrees Centigrade, then redissolves with further heating, only to reprecipitate on cooling. Albuminuria is frequently found, either with or without Bence-Jones proteinuria. The specific gravity is usually fixed and low. Casts are common; cells are rare. The NPN varies with the amount of renal damage, and is usually elevated terminally. Serum calcium is often elevated. The phosphorus is high or normal, helping to differentiate from hyperparathyroidism. Serum cholesterol is apt to be quite low, even down to 50 or 60 mg. percent. The basal metabolic rate is not elevated.

X-Rays are frequently diagnostic. Multiple "punched out" areas in the skull and ribs may make the diagnosis obvious. Often there is generalized osteoporosis. Sometimes there may be only osteoporosis or no X-Ray change in the diffuse type of myeloma without nodule formation. Solitary myeloma is uncommon but is more frequently found in the pelvis, dorsal vertebrae, or proximal portion of the femur.

The only positive way to diagnose multiple myeloma is by demonstrating the myeloma cells. They may be found in the peripheral blood smear in 8 to 10% of the cases. Aspiration biopsy of the bone marrow will usually demonstrate large numbers of the myeloma cells. However, if there has been X-Ray therapy over the tumor, as in our patient, aspiration may fail to show any cells. Then a surgical biopsy, preferably of a definite bone nodule will almost invariably provide the diagnosis.

At present, no curative therapy for multiple myeloma is known. However, definite palliation may be gained by use of roentgen treatments to the painful

areas, and transfusions whenever the anemia warrants their administration. Rapid surgical decompression if the patient develops paraplegia may restore the nerve functions and enable the patient to be comfortable for many months, perhaps for several years. Stilbamidine has been reported to help some patients.⁵ At this hospital and others,⁶ however, not much benefit has been obtained through use of Stilbamidine, and urethane is being studied. Loge and Rundles⁷ reported beneficial results with the use of urethane in four patients at Duke University Hospital recently. Harrington⁸ reported "good results" in three patients and "probably good" results in three others among 11 cases treated with urethane at the Boston City Hospital for periods up to two years. It is hoped that further progress in the field of therapy will be made as other new drugs are developed.

SUMMARY

The diagnosis of multiple myeloma is suggested by: progressive anemia, rapid sedimentation rate, extreme rouleaux formation; albuminuria, casts, and low, fixed specific gravity of the urine; azotemia without significant hypertension; multiple bone pains and bone tenderness; and progressive weight loss and cachexia. The diagnosis is even more probable if the patient is a male between the ages of 40 and 60, especially if he has single or multiple bone tumors, Bence-Jones proteinuria, hyperglobulinemia, and "myeloma cells" in the peripheral blood smear, or characteristic punched out areas on X-Rays of the skull or ribs.

REFERENCES

1. Blackman, S. S., Jr., Barker, W. H., Buell, M. V., On the Pathogenesis of Renal Failure Associated with Multiple Myeloma. Electrophoretic and Chemical Analysis of Protein in Urine and Blood Serum. *J. Clin. Investigation*, 23:163-166, 1944.
2. Schindler, J. A., A case of Multiple Myeloma with Liver Infiltration and a Low Prothrombin Purpura. *Annals Int. Med.*, 19:140-143, 1943.
3. Laake, H., Myelomatosis. Examination of Clinical Material. *Acta Med. Scandinav.*, 132:440-457, 1949.
4. Bayrd, E. D., and Heck, F. J., Multiple Myeloma, A Review of Eighty-Three Proved Cases. *J. A. M. A.*, 133:147-157, 1947.
5. Snapper, I., Stilbamidine and Pentamidine in Multiple Myeloma. *J. A. M. A.*, 133:157-161, 1947.
6. Propp, S., Gorham, L. W., and Kantor, S., Recent studies of Multiple Myeloma: Sternal and Rib Puncture and the Results of Treatment with Stilbamidine. *Blood*, 4:36-53, 1949.
7. Loge, J. P., and Rundles, R. W., Urethane (Ethyl Carbamate) Therapy in Multiple Myeloma. *Blood*, 4:201-216, 1949.
8. Harrington, W. J., Report presented at the American Federation for Clinical Research, Boston Chapter Meeting, April 25, 1949.

Voluntary Cooperative Effort

A. L. M. WIGGINS

Chairman of the Board, Atlantic Coast Line Railroad
Company, Hartsville, South Carolina

This meeting is the 45th anniversary of this association and is being held in the same city where it was founded in 1904. I am sure that the meetings through these 45 years have been invaluable to you in fellowship, in the discussions of subjects close to your lives and in the inspiration you have received to carry on a noble service in behalf of suffering humanity.

Equally significant is this 50th anniversary of the founding of the Relief Department of the Atlantic Coast Line Railroad Company. To me it is an inspiration to know that the directors and officers of this railroad system, before the turn of the century, had the vision, the sympathetic understanding of the problems and needs of the men and women who were associated in this enterprise, to set up a practical and workable and serviceable program to meet their needs against the adversities of illness and death. I can well imagine what courage it required for these directors to embark on a relatively new and untried venture in the conservation of human resources and in the protection of men and women against the vicissitudes of ill health. They were pioneers and the evidence of their foresight is that today, fifty years later, the people of this nation are just beginning to become aware of the importance of adequate provision of medical and hospital services on the basis of costs that will make possible the maximum use of such services.

I shall not attempt to present a history of the operations of the Relief Department of the Coast Line Railroad because I am sure that others who are better qualified will present the facts. I would like, however, to make a few observations about its operations.

In the first place, it is a cooperative undertaking based on the voluntary membership of those it is designed to serve. That it has commended itself to the employees of this railroad is proven by the fact that more than three-fourths of all permanent employees are members.

In the second place, it is not only cooperative among the members, but also as between the management of the railroad and the employees. Although the Coast Line does not contribute directly to the Relief Fund, it provides two hospitals with necessary equipment and the staff that is required for the operation and maintenance of the Relief Department as such, with an annual outlay by the Railroad of something

over \$100,000. Only last year the Company made a sizable expenditure for interior repairs, redecoration and modernization of these hospitals. The Relief Fund provided by its members bears the cost of the insurance, taxes, ordinary repairs and other costs of operation of the hospitals.

I believe you will agree that the operations of the Relief Department of the Atlantic Coast Line Railroad represent the finest degree of a wholesome interest on the part of an employer for the well-being of its employees that can be found. The facilities of these hospitals compare favorably with other hospitals, public or private, of similar size. One of them, with 75 bed capacity, is located at Waycross, Georgia, and the other of 50 bed capacity, at Rocky Mount, N. C. Their locations are convenient to the men working at any point on the Coast Line Railroad.

It is a matter of personal pride to me that the services provided and the quality of professional care that the patients receive in these hospitals are of the highest character. The members of the staffs are recognized by the medical profession as among the best.

All of this is provided at a cost to the individual of as little as 90 cents a month, which provides for medical treatment and hospitalization and, in addition, yields cash benefits for sickness, physical disability and death. Greater benefits may be had for those who desire it upon the payment of larger monthly dues.

You may be interested in knowing that the Relief Department operates under an Advisory Committee, of which six members are elected by the members of the organization and six appointed by the Company. The significant fact of the history of this management is that there has never been an instance in which matters under consideration for the operation of this department have received a tie vote. Every member of the Committee, whether representing employer or employees, is devoted to the one objective of providing the most for the least cost.

I present to you the splendid services of the Relief Department of the Atlantic Coast Line Railroad Company as an outstanding example of serviceable provision for the medical and hospital needs of people of moderate income at a cost they can afford to pay. The important fact is that this has been done by voluntary cooperative effort in which there is neither taxpayer subsidy nor the compulsion of governmental intervention.

I need not point out to this group of men whose lives are devoted to the service of mankind the many

* (An address delivered before the Atlantic Coast Line Surgeons, Savannah, Ga., March 31, 1949.)

proposals now under consideration by the American people for some form of governmental compulsion in providing enlarged medical and hospital services for people of moderate means. Proposals have been made whereby the taxing power of government shall be used to provide these services. Some of the plans under consideration are recognized to be but the first steps toward the socialization of medicine. This is not at all a new idea. Many countries of Europe have had forms of socialized medicine, either compulsory or voluntary, which go back a hundred years. Germany instituted a compulsory health and disability insurance program in 1879. Great Britain passed its national health insurance act in 1911, and beginning 1948, substituted a general health service for everybody. With in recent years, most of the countries of Europe have moved into more complete systems of socialized medicine. These developments grew out of the trends toward socialization generally, but in the case of medicine were accelerated because of a combination of the ravages of war, the scarcity of doctors and hospital facilities and increased costs of modern equipment and facilities for medical treatment.

It is, therefore, no surprise that these developments in other countries should have an effect on the thinking in this country nor that some of the factors which have brought about socialized medicine in other parts of the world are present here.

You, better than I, know that more and more of our people are seeking medical and hospital service than ever before. When I was a boy, it was unusual for a person to go to a hospital except for a serious operation.

Doctors were available to come to the home any hour of the day or night, not only in the cities but throughout rural districts, often at considerable distance, and with great personal sacrifice, traveling by buggy over dirt roads in many cases, but taking care of the sick wherever they were as best they could. Of course, in those days having a doctor was resorted to only in extreme cases.

Today the situation is entirely changed. The public is better informed about health. There is a more frequent call upon the medical profession for diagnosis and treatment. Modern equipment is needed in many cases. Necessarily, there is less treatment in the home and more in the doctor's office and in the hospital. More lives are saved, more suffering relieved and now we have reached the point where every man and woman demands the accessibility of medical and hospital services, and what is more, at a price they can afford to pay.

As a banker in a small town for many years, I saw something of the financial hardships of working men when a member of their family had a long, serious illness that entailed expenses beyond their capacity to pay. In some cases, it required two or three years of

saving for a man to meet his obligations. It is out of such situations as these that has grown a widespread demand for financing plans for medical and hospital care on a basis of some form of insurance whereby small amounts may be paid regularly that will provide against the cost of an unusual illness should it occur.

The American people are meeting this need to a substantial extent through voluntary associations and insurance programs of a voluntary nature. More than one-third of all people now have voluntary hospital insurance, one-sixth have surgical operation insurance and about one-fifteenth belong to medical care organizations. In addition, 31 million people have disability benefit insurance as sold by the insurance companies.

I am convinced that an adequate expansion of voluntary programs of medical and hospital insurance can meet the needs of the American people, with greater satisfaction, with more adequate service and with less cost than can any compulsory system paid for by the taxpayer and operated by the Government. I am equally sure, however, that unless more adequate provision is made for more people to secure needed medical and hospital services under plans that provide moderate regular payments, we may expect Government to play a continuing larger part in meeting this problem through some form of compulsory contributions. It seems to me that the question largely resolves itself into whether or not plans and programs will be further developed to meet these demands of the American people on a voluntary and cooperative basis or shall we stand by and see government undertake to do the job.

I am further convinced that once Government undertakes a compulsory program of medical and hospital insurance, it will be but a step toward the eventual socialization of medicine. The first step will be Government insurance to provide funds with which an individual may be able to pay his own doctor and the hospital of his choice. The next step will be the standardization of fees charged by the doctors. The third step will be to limit the number of patients a doctor may serve, and the final end will be the complete socialization of medicine with the doctors drawing their compensation as paid employees of the Government.

I have presented these possible developments rather brutally because I am fully convinced that a large part of public opinion is demanding greater security against the possibility of the heavy costs arising out of serious illness or accident. I am also convinced that with the medical profession now becoming fully alert and aware of this demand and of the threat of socialization, the doctors will work with each other and with other leaders who are interested in this problem to enlarge and multiply and improve tested plans that will meet the needs and the desires of the American people. You are thoroughly familiar with organizations

and efforts along this line and I think there is no better example of what can be done than the fine work of the Relief Department of the Coast Line Railroad over the past half century.

It is not only medicine that is confronted with the threat of eventual socialization. We have but to read the statute books of our land to discover that the concept of socialization has already permeated much of our national life. In this country, the railroads have not as yet felt the direct hand of socialization, but what has happened throughout the world to railroads is now beginning to cast its shadow here. In the early years of railroad transportation, before the advent of the automobile, the truck and the airplane, the railroad was virtually a monopoly in transportation. Government, therefore, seized control of the railroads in a tight clasp of regulation. In spite of the fact that these other means of transportation are now sharp competitors with the railroads, the firm grip of government regulation has not been relaxed. Laws are passed and regulations promulgated that force the railroads to engage in uneconomic practices. Made work without compensating value is created. The operation of some trains is required where the revenue produced is far less than the cost of the crew to operate the train. In many cases unrealistically low rates are maintained by Government fiat rather than determined by the economic value of the service performed.

Furthermore, the leadership of organized labor in the railroad industry has forced the railroads to pay for much work not performed, to set up uneconomic rules under which costs have multiplied without compensating benefit, either to the railroads or to the employees and there has developed a rigidity in the use of personnel that makes economic and efficient operation almost impossible.

Furthermore, Government has not been unkind to the competitors of the railroads. Tax money has built highways which in the course of a few years require rebuilding through their use by heavy trucks engaged in the transportation of property. Airports are built at public expense and air transportation directly subsidized out of the public treasury. Although the railroads carry 94% of all inter-city mail, they receive less for carrying this mail than the airlines receive for carrying the other 6%. Barge and steamboat lines operated at Government expense transport freight that would otherwise move by rail. The ironical fact is that part of the \$1 billion per year the railroads pay in taxes is used by Government to subsidize their competitors.

Time does not permit a discussion of the problems of the railroads, but may I point out the fact that it requires more than men to operate a railroad. It requires capital and a lot of it. For every employee of the railroads of this country, there is an equivalent of more than \$20,000 of capital investment to provide

every job. That capital is indispensable to provide the roadway, the motive power, the shops and equipment. It can be acquired only through investment and investment money can be obtained only by paying it a reasonable rate of return. In only one year in the past twenty-eight have the railroads earned as much as 5% on their property investment, and last year the net return for all the railroads in the United States was only 4.38%. Within recent years, the railroads have secured the necessary capital for modernization, for new cars, for safety equipment and for modern motive power only through borrowing and through retaining most of their inadequate earnings for re-investment in the property. More than two-thirds of the earnings of most railroads is retained for improving the property and paying off debt and the stockholder has had to be content with receiving less than the one-third remaining.

Only when the railroads are permitted to earn at least six or seven percent on their investment will they be able to attract adequate capital to meet their continuing needs for improvement, modernization and efficient operation.

It is a cold fact that unless railroads are able to finance their continuing capital needs, they will die of financial malnutrition. And here the spectre of socialization arises.

The railroads are indispensable to the welfare of this nation. Every day they haul 1.8 billion ton miles of freight, which is equal to hauling one ton for a distance of 12½ miles every day for every man, woman and child in the United States, and the remarkable thing is that they haul one ton one mile for less than 1½ cents. Truly, the cost of rail transportation is a bargain in these days of high prices.

To serve the American people in peacetime and to transport the essential supplies in wartime, the trains must run. It is unthinkable that the American people will permit the largest, the most efficient and the most economically operated transportation system in the world to die. The final recourse, no doubt, would be socialization. This is resort of most of the countries throughout the world.

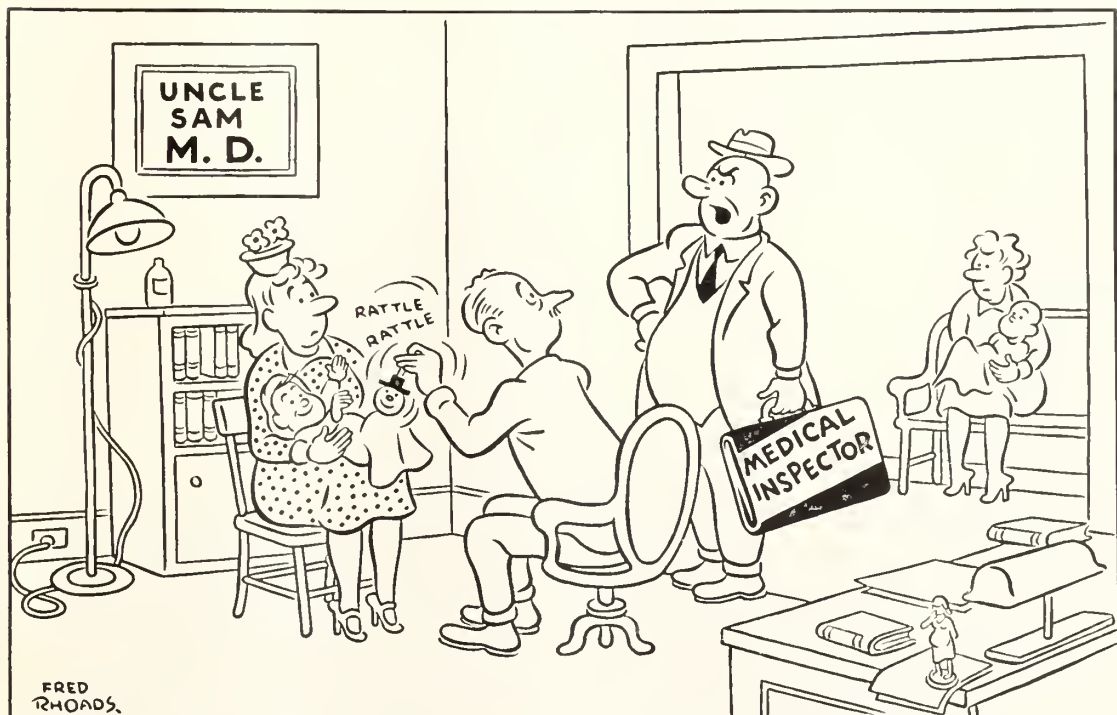
We had a test of the Government operations of railroads in this country during World War I, and it cost the taxpayers \$1,616,000,000. During World War II, under private operations, the railroads not only cost the taxpayers nothing and freight rates remained at pre-war levels, but in the four year period 1942-45, the railroads actually paid to the government in taxes an average of \$2.5 million per day.

I believe that the correct answer is one that will appeal to the American sense of fair play and honest dealing. It is that we preserve the rail transportation system of this country through reasonable financial nourishment, proper rates, sound economic policies on the part of Government supervisory agencies, railroad

management and labor. With such environment, the necessary capital will be forthcoming, rail services will be further improved and the American people will be fully satisfied with its rail transportation system.

What is this socialism about which we are concerned? The best answer I can give is a recent statement in the London Sunday TIMES by Charles Morgan:

"BRITISH SOCIALISM. In England there is no incentive to bold undertakings . . . Today, it is safer to be a bureaucrat than a maker and the young men know it . . . Socialism is competition without prizes, boredom without hope, war without victory, and statistics without end. It takes the heart out of young men . . . it is not only politically false, but morally destructive."



"PLAYING ON THE JOB, EH? WE PAY YOU FOR YOUR MEDICAL SKILL, NOT YOUR PERSONAL INTEREST."

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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ROBERT SPANN CATHCART

The death of Dr. Robert Spann Cathcart brought to an end a life rich in accomplishments. He was among the first in South Carolina to specialize in surgery. He strove continuously to raise the standards of the medical profession, particularly of his chosen field. Dear to his heart was the Southern Surgical Association, of which he was at one time president. For many years he served as governor of the American College of Surgeons. As professor of surgery at the Medical College of the State of South Carolina, he exerted a profound influence over medical education in the state.

If it is possible to evaluate his many services probably the most valuable were those to the Medical Society of South Carolina. As chairman of the important finance committee he protected the large endowment funds, and saw them increase greatly during his lifetime. He was influential in the construction of the old Roper Hospital building which is still serving the community, and the Medical College for teaching purposes. To his efforts, in great part can be attributed the construction of the new Roper Hospital building, an accomplishment of which he could be justly proud.

Dr. Cathcart was a man of strong convictions. He fought hard to maintain what he thought was right. In spite of failing health, his interest in medical affairs continued to the end. In his death the medical profession loses a strong and valuable leader.

W. H. P.

1949 ANNUAL SESSION

More than four hundred physicians, not to mention their wives and guests, attended the recent annual meeting at Myrtle Beach. And from the opinions expressed generally, it was one of the most enjoyable and at the same time productive meetings ever held.

The Pee Dee Medical Association served as hosts and were most gracious with their hospitality. The entertainment furnished by the Liberty Life Insurance

Company of Greenville was particularly acceptable and the annual banquet with Dick Reeves of Charleston as guest speaker, was outstanding.

The scientific papers were well received. The guest speakers are to be congratulated upon their addresses since they spoke in terms of the man in general practice and did not stray off upon the cloud of some specialty.

The House of Delegates holding an all day session for the first time in years worked seriously. Several subjects of marked importance were discussed and taken care of.

All in all the 1949 session will probably go down in history as a memorable one.

OUR NEW LEADERS

Dr. Roderick Macdonald of Rock Hill was installed as President of our Association for the coming year, succeeding Dr. R. B. Durham of Columbia. Dr. Macdonald brings to his task considerable experience in the work of the Association. First, as a worker in his own county and district societies, then as a member of Council and as Chairman of Council, and finally after a year as president-elect, Dr. Macdonald has seen what has been done and what needs to be done.

As President-Elect, the Association selected Dr. Wilbur R. Tuten, Sr., of Fairfax. A general practitioner in a small community Dr. Tuten brings to the Association a knowledge gained at first hand of the problems of general practice. Dr. Tuten has also served as a member of the State Board of Medical Examiners for a number of years, as a leader in his district medical society, and as Vice President of the Association.

The newly elected Vice President is Dr. Archie Sasser of Conway. A general surgeon, a community leader and builder, a member of the Board of Directors of the Blue Cross, Dr. Sasser will bring experience and sound judgment to the Association.

MEDICAL CARE PLAN

The ground work for a medical care plan was laid at the recent meeting of the House of Delegates. A

committee headed by Dr. J. D. Guess, presented its report which called for the establishment of such a plan, and this was adopted unanimously.

Whether the plan will come to fruition and whether it will function will be determined by the members of the Association. Under the law, such a plan must have the signed endorsement and agreement to participate of fifty percent of the practicing physicians of the state before it can be operated.

The Plan, as proposed, has been presented in the Journal and the main features of the Plan will again be sent to all members of the Association. It is hoped that every physician in the state will study the Plan carefully and will be ready to become an active participant when the time arrives.

Voluntary prepayment medical care is the need of the hour. Otherwise, we may expect the compulsory insurance plan of Mr. Truman. South Carolina has been extremely tardy in making provision for a medical care plan and it will take hard work along with enthusiastic backing from all physicians to bring our state in line with our neighbors.

PEDIATRIC SEMINAR

The Southern Pediatric Seminar will hold its 29th Annual Session at Saluda, N. C. from July 18 to July 30. Indications point toward one of the highest attendances on record.

The Seminar is now accepted by the Academy of General Practice for credits toward post-graduate study. For this reason those of our members who belong to the Academy should be particularly interested in considering attendance this summer. A certain number of scholarships are available through the S. C. State Board of Health, and information concerning them may be obtained from Dr. Hilla Sheriff, Columbia, S. C.

TREATMENT SCHEDULES SOUTH CAROLINA PUBLIC HEALTH HOSPITAL, FLORENCE, SOUTH CAROLINA

A. Syphilis

Preparation used, Procaine Penicillin G in peanut oil, with 2% Aluminum Monostearate, each cc containing 300,000 units, injected intramuscularly.

1. The following schedule became effective June 9, 1948 for the treatment of primary, secondary, early latent, late latent, and congenital syphilis over 4 years of age and who are showing no late manifestations.

1st day	2cc	
2nd day	1cc	
3rd day	1cc	This makes a total of 3,000,000 units. Arsenical and bismuth preparations are no longer used.
4th day	1cc	
5th day	1cc	
6th day	1cc	
7th day	1cc	
8th day	1cc	
9th day	2cc	

2. The following schedule became effective June 9, 1948 for the treatment of neuro-syphilis; primary and secondary cases which have relapsed; congenital syphilitics who show late manifestations i.e., gumma, paresis, tabes, interstitial keratitis; late manifest syphilis i.e., gumma of skin, Charcot's joint, late syphilis.

1st day	2cc	
2nd day	1cc	
3rd day	1cc	
4th day	1cc	
5th day	1cc	
6th day	1cc	
7th day	1cc	This makes a total of 6 million units.
8th day	1cc	
9th day	1cc	
10th day	1cc	
11th day	1cc	
12th day	2cc	
13th day	2cc	
14th day	2cc	
15th day	2cc	

3. The following schedule became effective June 15, 1948 for the treatment of congenital syphilis in infants under 4 years of age.

Preparations: Penicillin Crystalline G injected intramuscularly.

40,000 units are injected every three hours until the patient has received 72 injections. This makes a total of 2,880,000 units.

4. The following schedule became effective June 23, 1948 for the treatment of CHANCROID and LYMPHOGRANULOMA VENEREUM.

Preparation; Sulfadiazine

First dose consists of 4 grams of sulfadiazine together with an equal amount of sodium bicarbonate.

Thereafter, the patient will receive 1 gram of sulfadiazine with an equal amount of sodium bicarbonate four times daily.

This schedule is given for five days, unless discontinued or prolonged at the discretion of attending physician.

5. The following schedule became effective June 28, 1948 for the treatment of GRANULOMA INGUINALE:

Preparation; Streptomycin dihydrochloride

One half gram is injected intramuscularly every 3 hours for 40 doses. This will make a total of 20 grams over a 5 day period.

If the patient has shown only slight improvement two months following completion of first course of streptomycin, he is given one half gram every three hours for 80 doses, making a total of 40 grams.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

MEDICAL CARE PLAN APPROVED

The House of Delegates in annual session at Myrtle Beach on Tuesday, May 17th, approved in toto, the report of the Committee on Medical Service, of which Dr. J. D. Guess of Greenville is Chairman.

The Report, and the approval by the House of Delegates included the fee schedule, prepared in advance by the professional committee appointed by Council, and the By-Laws which Council had previously approved.

The most gratifying feature of the whole procedure was the absence of argument or misunderstanding with respect to the fee schedule and general purpose of the Plan, and their general favorable acceptance by the House of Delegates.

Copies of the schedule, in mimeographed form had been mailed to the Delegates for study in advance of the meeting. Its acceptance is proof of its fairness and a tribute to the conscientious work of the professional committee in charge of its preparation.

On Sunday, May 22nd, the Board of Directors met in Columbia at the call of Dr. Guess, for the purpose of organization. The following officers were elected: Dr. J. D. Guess, Greenville, President; Dr. George W. Wilds, Hartsville, Vice President; Dr. George Dean Johnson, Spartanburg, Secretary; and Dr. J. D. Ashmore, Greenville, Treasurer.

Dr. Guess appointed several committees and these were directed to proceed at once with the preliminary work necessary to get the Plan into operation at the earliest possible date. As this is written, work is being commenced on subscription rates, contracts, and all of the numerous incidental procedures.

At the same meeting, Mr. Frank E. Smith of Chicago, Executive Director of Associated Medical Care Plans, was present and discussed at length the nature of the work of his organization, and gave valuable suggestions for guidance of the Board of Directors in setting up the South Carolina Medical Care Plan.

The Board voted to make application immediately for admission as an associate member of AMCP, and was assured that this would be favorably acted upon at the next meeting of the organization in Atlantic City, June 4th.

The entire fee schedule is carried elsewhere in this Department, and members of the Association are urged to give it their consideration. Steps will be taken in the very near future to secure the requisite number of participating physicians, so that the Plan may begin operating with as little delay as possible.

SCHEDULE

of
Professional Fees
State-Wide

THE SOUTH CAROLINA MEDICAL CARE PLAN

The Special Program
of the
South Carolina Medical Association

YOUR DOCTOR'S PLAN

FEE SCHEDULE

The fees listed in this schedule are the fees that will be paid by the Plan, directly to the attending physician. In the case of service indemnity (unlimited) subscribers, they will be the entire fee to be collected in each instance. In the case of cash indemnity subscribers (limited), they will apply on the total fee agreed upon by the physician and his patient.

In case of multiple, associated surgical procedures, the fee for all will be the largest fee for any one of them.

In case of multiple, non-associated surgical procedures, the general principle will be to set a fee at that of the major procedure plus one-half the fee for the minor procedure. However, such cases will receive individual consideration by the Central Professional Service Committee.

Surgical and obstetrical procedures not covered in the fee schedule will receive individual consideration by the Central Professional Service Committee.

Medical and Surgical conditions which come under the Workmen's Compensation Law are not covered by the contract with the subscriber.

DERMATOLOGICAL SURGERY

- | | | |
|------|---|----------------|
| 0001 | Removal of benign skin lesions:
Verrucae, nevi, keratoses, kaloids
leukoplakia, etc.
Depending on size and number
(not including microscopic examination of tissue) ----- | \$5.00—\$20.00 |
| | Removal of malignant lesions of the skin; or
mucous membrane (without x-ray therapy or microscopic examination of tissue) | |
| 2 | Up to 2.0 c.m. diameter ----- | \$ 35.00 |
| 3 | More than 2.0 c.m. diameter ----- | 50.00 |
| 4 | Biopsy and report ----- | 10.00 |

5	Avulsion of finger or toe nails -----	10.00
6	Removal of sebaceous cyst -----	10.00

EAR, NOSE AND THROAT

1091	Tonsillectomy and adenoidectomy		54	Thyroglossal cyst resection -----	75.00
	—over age 15 -----	\$ 35.00	55	Branchial cyst resection -----	75.00
92	—15 or under -----	25.00	60	Ligation of great vessels of neck -----	35.00
93	Tonsillectomy—under age 15 -----	25.00	61	Mixed tumor of parotid resection ----	100.00
94	—over age 15 -----	35.00	62	Removal of submaxillary gland -----	50.00
95	Adenoidectomy -----	15.00	63	Submucous resection -----	50.00
96	Incision and drainage of peritonsillar abscess -----	10.00	64	Submucous resection with cartilaginous transplant -----	100.00
1010	Incision and drainage of retro-pharyngeal abscess -----	20.00	65	Turbinectomy -----	10.00
11	Resection of ramula, resection—top ----	50.00	70	Intranasal sphenoid and ethmoid, one side -----	50.00
12	Ring operation -----	35.00	71	both sides -----	75.00
	Removal of lymphoid tissue from pharynx and nasopharynx or		72	Intranasal frontal -----	50.00
13	electrocoagulation of same -----	25.00	73	Intranasal antrum, one side -----	25.00
	Removal of foreign body from pharynx such as fishbone		74	both sides -----	25.00
14	Simple direct, as from tonsil -----	5.00	80	Electrocoagulation of turbinates (each side) -----	10.00
15	Requiring indirect laryngoscopy (incision) -----	10.00	81	Radical operation for malignancy of sinus such as muore type of operation -----	100.00
	Removal of foreign body from hypopharynx or		82	External ethmoid -----	100.00
16	larynx by direct laryngoscopy -----	25.00	83	External frontal lynch type -----	100.00
1020	Direct laryngoscopy (diagnostic) ----	10.00	84	External frontal complete with obliteration of sinus -----	125.00
21	Direct laryngoscopy and biopsy -----	35.00	85	External frontal with complete obliteration of frontal and wide exposure of dura (osteomyelitis of frontal bone) -----	125.00
22	Direct laryngoscopy and removal of benign tumor -----	50.00	1100	Radical antrum -----	75.00
23	Direct laryngoscopy and cauterization of tuberculous larynx -----	25.00	1	Bilateral -----	100.00
24	Direct laryngoscopy and dilatation stricture -----	15.00		Operation of congenital occlusion posterior nares	
30	Bronchoscopy (Diagnostic) -----	35.00	2	(Depends somewhat on type of operation) -----	100.00
31	Bronchoscopy and lung mapping -----	40.00	3	Antral irrigation -----	5.00
32	Bronchoscopy and biopsy -----	35.00	4	Incision and drainage of septal abscess	10.00
33	Bronchoscopy with dilation of stricture, first -----	35.00	5	Removal of nasal polyps, one side ----	20.00
34	thereafter -----	25.00	6	both sides ----	30.00
35	Bronchoscopy and removal of foreign body -----	75.00	7	Reduction of nasal fracture -----	25.00
36	Bronchoscopy and removal of benign tumor (several bronchoscopies may be necessary) -----	150.00	1110	Simple mastoidectomy -----	100.00
37	Bronchoscopic removal of foreign body of lung with fluoroscopic guidance--	125.00	1	Double -----	125.00
40	Laryngofissure -----	100.00	2	Radical mastoidectomy without graft--	125.00
41	Laryngectomy -----	150.00	3	With graft -----	150.00
1042	Arytenoidectomy -----	100.00	4	Fenestration operation -----	150.00
43	Tracheotomy -----	75.00	5	Modified radical mastoid -----	125.00
44	Plastic closure of tracheotomy wound--	25.00	20	Simple plastic for "flop" ear -----	50.00
45	Thyroidectomy (removal thyroid cartilages) -----	75.00	21	Paracentesis of drum -----	5.00
50	Incision and drainage deep abscess of neck without tracheotomy -----	50.00	22	Incision and drainage of canal wall abscess -----	5.00
51	With tracheotomy -----	75.00	23	Removal of polyps from ear -----	10.00
52	Biopsy of gland of neck -----	25.00	24	Removal of external ear for malignancy -----	50.00
53	Removal of benign tumor of neck ----	50.00	30	Radical mastoid with drainage of petrous tip -----	150.00
			1131	Mastoidectomy with packing off of sigmoid sinus -----	125.00
			32	Diagnostic esophagoscopy -----	35.00
			33	Diagnostic esophagoscopy with biopsys -----	35.00
			34	Esophagoscopy with dilatation of stricture -----	35.00
			35	For subsequent up to total of 4-----	15.00



Congestive Heart Failure...

"The most striking effects were seen in cases of hypertensive heart failure. . . . There is a rapid fall in the raised right auricular pressure with a conspicuous increase in the output of the heart."¹

SEARLE

AMINOPHYLLIN*

—improves cardiac failure by effecting an improved heart action with increased blood flow, and eliminating edema fluids by the renal route.

Searle Aminophyllin is indicated in paroxysmal dyspnea, bronchial asthma, Cheyne-Stokes respiration and selected cardiac cases.

ORAL—PARENTERAL—RECTAL DOSAGE FORMS

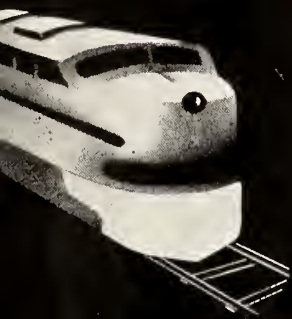


*Searle Aminophyllin contains at least 80% of anhydrous theophylline. G. D. Searle & Co., Chicago 80, Illinois.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Howarth, S.; McMichael, J., and Sharpey-Schafer, E. P.: The Circulatory Action of Theophylline Ethylene Diamine, Clin. Sc. 6:125 (July 17) 1947.

36	Dilatation of cardiospasm under fluoroscopic guidance -----	35.00	54	Tarsorrhaphy -----	50.00
40	Retrograde dilatation of esophagus-----	5.00	55	Trichiasis—electrolysis -----	20.00
41	String dilation of esophagus -----	5.00	60	Tumor, exenteration of orbit -----	125.00
42	Esophagoscopy with removal of foreign body -----	75.00	61	Toti—Mosher -----	125.00
43	Esophagoscopy and removal of foreign body from stomach without fluoroscopy -----	75.00	62	Visual fields -----	5.00
44	With fluoroscopy -----	100.00	63	Zanthomas (Excision) single -----	10.00
45	Magnetic removal of foreign body of stomach with fluoroscopy -----	50.00	64	multiple -----	15.00
46	Diverticulectomy -----	100.00	GENERAL SURGERY		
EYE			Abdomen		
2001	Barkan Operation -----	\$ 50.00	3001	Gastrotomy -----	\$100.00
2	Biopsy of conjunctiva -----	5.00	2	Gastro-enterostomy -----	125.00
3	Blepharorrhaphy: suture of eye lid-----	10.00	3	Cholecystectomy -----	125.00
4	Cataract—Intracapsular or extra capsular -----	150.00	4	Cholelithiasis -----	100.00
5	Canthotomy -----	7.50	5	Intestinal obstructions -----	100.00
6	Chalazion excision—or incision and and curettage -----	15.00	6	Tumors in abdominal cavity -----	100.00
2010	Conjunctiva flap for corneal ulcer -----	25.00	10	Wounds of abdomen—perforating -----	100.00
1	Conjunctiva flap with excision of iris for prolapse -----	75.00	11	Exploratory laparotomy -----	\$50.00—100.00
2	Cornea—paracentesis -----	25.00	12	Gastric ulcer, excision -----	100.00
3	Corneal ulcer, cautery -----	7.50	13	Gastrectomy -----	150.00
4	Corneal Transplant -----	150.00	14	Peptic ulcer, closure, perforated -----	100.00
5	Cornea tattoo -----	50.00	15	Duodenal ulcer, excision (Pyloroplasty) -----	125.00
6	Cyclodiathermy—ciliary body -----	50.00	16	Pyloric stenosis (Rammstedt's in infant) -----	75.00
2020	Dacryocystotomy -----	15.00	20	Intestines (small) resection -----	100.00
1	Dacryocystectomy -----	75.00		Colon (resection) with one closure colostomy—	
2	Drainage of lid—abscess -----	10.00	21	individual consideration—maximum ---	125.00
3	Entropion or Ectropion -----	50.00	22	Colostomy, palliative (no subsequent surgery) -----	75.00
4	Enucleation—		23	Subdiaphragmatic abscess -----	100.00
5	with simple exopiant or implant -----	100.00	24	Biliary surgical drainage, common duct and cholecystostomy -----	100.00
5	Evisceration -----	75.00	25	Diverticulum, intestinal—individual consideration maximum -----	125.00
6	Excision of lesion of iris -----	100.00	30	Cholecystostomy -----	100.00
30	Fulguration of eye lid (warts, etc.)---	7.50	31	Cholecystoduodenostomy -----	125.00
31	Glaucoma—Filtrating operation -----	100.00	32	Pancreas, drainage -----	100.00
32	Iridectomy optical -----	100.00	33	Splenectomy -----	125.00
33	Intra-ocular foreign body -----	100.00	40	Freeing of adhesions -----	100.00
34	Intra-orbital foreign body -----	25.00	41	Esophageal, Diverticulum—one stage --	100.00
35	Lachrymal duct stenosis probing -----	10.00	42	—two stages --	125.00
36	Needling after cataract -----	25.00	43	Pilonidal cyst—excision -----	50.00
37	Needling after congenital cataract -----	50.00	3090	Appendectomy, simple -----	75.00
40	Pterygium -----	25.00	91	Appendectomy, drainage case -----	100.00
41	Perforating wound or cornea suture with or without conjunctiva flap -----	75.00	92	Appendiccal abscess—drainage -----	60.00
2042	Ptosis operation -----	100.00	Breast		
43	Reattachment of retina -----	150.00	3101	Radical amputation -----	100.00
44	Removal of foreign body cornea -----	5.00	2	Simple removal -----	50.00
45	Refraction with mydriatic -----	7.50	3	Removal of cysts, or benign tumor-----	20.00
46	Suture of conjunctiva -----	10.00	4	Abscess or abscesses -----	20.00
50	Squint—one stage -----	75.00	Chest, Thoracic Surgery		
51	—two or more stages -----	100.00	3201	Complete Thorocoplasty -----	150.00
52	Stye—drainage -----	5.00	2	Pneumonectomy -----	150.00
53	Symblepharon -----	50.00	3	Lobectomy -----	125.00
			4	Removal of intra-thoracic tumor -----	125.00
			5	Rib resection—drainage of empyema--	50.00
			6	Lung abscess—bronchoscope drainage --	50.00
			10	Phrenicectomy -----	30.00



the difference
is noteworthy
Trimeton

(brand of propenpyridamine)

TRIMETON* differs from most other antihistaminic agents in not being a derivative of ethanolamine or ethylenediamine. This difference is noteworthy and is responsible for the gratifying clinical results obtained. In one study of 227 patients with various allergic conditions¹

83% obtained benefit from Trimeton

Side effects, common to all antihistaminics, occur with TRIMETON, but only a few patients find that they cannot tolerate the drug.¹

Relief from allergic symptoms is usually obtained with one TRIMETON 25 mg. tablet three times daily; in some patients half this dosage is sufficient. The action of TRIMETON lasts from four to six hours.²

PACKAGING: TRIMETON (1-phenyl-1-(2-pyridyl)-3-dimethylaminopropane) is available in 25 mg. tablets, scored, in bottles of 100 and 1000.

BIBLIOGRAPHY: 1. Brown, E. A.: Ann. Allergy 6:393, 1948. 2. Wittich, F. W.: Ann. Allergy 6:497, 1948.

*TRIMETON trade-mark of Schering Corporation

Schering
CORPORATION • BLOOMFIELD, NEW JERSEY
IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL

TRIMETON



11	Phenicotomy	30.00
12	Empyema, closed drainage (thoracotomy)	35.00
13	Pleura—paracentesis	7.50
14	Aneurysmorrhaphy	125.00
20	Open drainage of lung abscess	100.00
21	Esophagogastrostomy	150.00

Neck

3301	Thyroidectomy	100.00
2	Ligation (not followed by thyroidectomy)	35.00
3	Lobectomy (see chest)	125.00
4	Dissection of glands for cancer	100.00
5	Thyroglossal cyst	75.00

Hernia

3401	Unilateral	75.00
2	Bilateral	100.00

Rectum

3501	Hemorrhoidectomy—external	35.00
2	Fistula in Ano	40.00
3	Prolapsed rectum—cutting	75.00
4	Cancer of rectum	125.00
5	Ischiorectal abscesses or cysts perineal	25.00
10	Hemorrhoidectomy, internal	50.00
11	Polypectomy	25.00
12	Peri-rectal abscess—drainage	5.00

Tendons

3601	Repair one or more, individual consideration—maximum	\$75.00—100.00
2	Lengthening	35.00
3	Resection of cysts of tendons	15.00
4	Septic finger—tendon sheath involve- ment	35.00
5	Septic hand, bad, sheath involvement and compartments	50.00

Tumors

	Abdominal (see 3006)	100.00
	Removal of malignant tumors, skin or mucous membrane	\$35.00—75.00
3701	Other malignant tumors	35.00
2	Benign tumors (Epulis)—individual consideration—maximum	20.00

Varicose Veins

3801	Cutting operations, including injections, one leg	35.00
2	Both legs	50.00

GYNECOLOGY

40001	Hysterectomy	\$100.00
2	Suspension of uterus	75.00
3	Complete cystocele, rectocele hysterectomy	150.00
4	Salpingectomy and/or oophorectomy	75.00
5	Repair of cervix	35.00
10	Complete cystocele, rectocele and all repair	100.00

11	Resection of ovary	75.00
12	Repair of perineum	50.00
13	Cauterization of cervix	10.00
14	Conization of cervix	25.00
15	Fistula—recta or vesico vaginal	150.00
20	Cul-de-sac, drainage	25.00
21	Myomectomy	75.00
22	Removal of uterine polyp	35.00
23	Amputation of cervix	50.00
24	Trachelorrhaphy	35.00
25	Atresia of Vagina—correction	20.00
26	Plastic	100.00
30	Bartholin's Gland, incision	10.00
31	Bartholin's Gland, excision	30.00
32	Urethral caruncle (removal)	10.00
33	Labial tumors and cysts (removal)	15.00
34	Uterine displacements, with repair of cervix and perineum	100.00
40	Ligation of tubes	50.00
50	D & C	35.00

NEUROSURGERY

Spine

5001	Lumbar Puncture	\$ 10.00
2	Cisternal puncture	15.00
3	Pantopaque myelography	25.00
10	Laminectomy for spinal cord tumor	125.00
11	For chordotomy or rhizotomy	100.00
12	For extradural abscess	100.00
13	For traumatic paraplegia	100.00
14	For similar major conditions	100.00
20	Hemilaminectomy for ruptured disc, lumbar	100.00
21	Combined with orthopedic fusion	150.00
22	Hemilaminectomy for ruptured disc, cervical	100.00
5023	Resection of meningocele	50.00

Peripheral Nerve

5101	Neurorrhaphy or Neurolysis	100.00
2	Neurolysis or neurorrhaphy combined with orthopedic operation	125.00
3	Neurolysis or neurorrhaphy combined with plastic operation	125.00
4	Neurectomy—resection of neuroma	50.00
10	Resection of peripheral nerve tumor	75.00
11	Biopsy of peripheral nerve	15.00
12	Resection of cervical rib	50.00
13	Section of scalenus anticus muscle	50.00

Sympathetic Nervous System

5201	Sympathectomy—cervical or lumbar	125.00
2	Sympathectomy—staged or bilateral	150.00
3	Periarterial sympathectomy	75.00
4	Presacral neurectomy	100.00
5	Paravertebral sympathetic nerve block	15.00

Cranial Nerves

5301	Rhizotomy for tic douloureux
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FOR PATIENTS WITH ALCOHOLIC PROBLEMS

. . . . The Farm

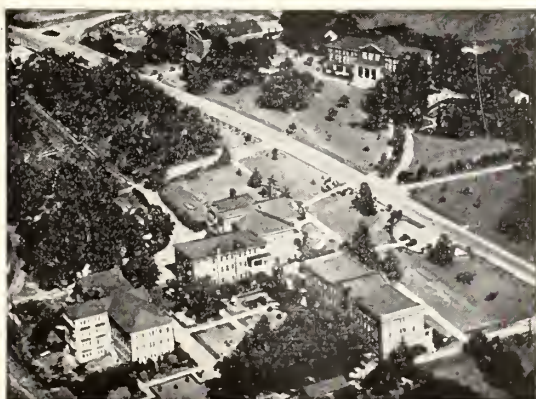
A non-institutional arrangement in Howard County, Maryland, for the individual psychological rehabilitation of a limited number of selected voluntary patients with ALCOHOL problems — both male and female — under the psychiatric direction of Robert V. Seliger, M.D.

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FOR THE TREATMENT OF NERVOUS
AND MENTAL DISEASES

GROUNDS 600 ACRES

Buildings Brick Fireproof - Comfortable
Convenient - Site High and
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Terms Reasonable

Established 1890

MILLEDGEVILLE, GA.



From where I sit
by Joe Marsh

Remember How We Talked?

It went like this at the Hooper's last night. Hap's eighteen-year-old daughter is talking about "a real gone guy — solid — out of this world, but def."

"Now what kind of language is that supposed to be?" Hap barks. "Can't she speak English?"

"I'll translate it for you," Ma Hooper says, "in the language of the twenties, when you were about twenty years old. She simply means this fellow is the 'cat's whiskers.' Remember how we used to talk sometimes?" Hap went back to reading his newspaper.

From where I sit, it's easy to criticize the other person when we don't take a good long look at ourselves. Sure, there'll always be some differences. I'm fond of a temperate glass of beer and maybe you would prefer ginger ale—but let's just live and let live. Because when we go out of our way to find things to find fault with in others, chances are they can find a few in us.

Joe Marsh

	Subtemporal approach	125.00
2	Injection or avulsion, peripheral branch. V nerve	15.00
3	Cerebellar craniotomy, section V, VIII, IX or X nerves	125.00
4	Combined with laminectomy	150.00
10	Anastomosis of cranial nerves	75.00
11	External section of cranial nerves for torticollis	50.00
12	Combined with laminectomy	125.00
13	Cranial nerve suture	50.00

Brain

5401	Pneumoencephalography	25.00
2	Ventriculography	40.00
3	Diagnostic or exploratory trephine	50.00
4	Repair of laceration of scalp	10.00
10	Craniotomy for compound fracture, skull	125.00
11	Craniotomy for osteomyelitis, skull ...	125.00
12	Craniotomy for skull tumor	125.00
13	Subtemporal decompression	100.00
14	Cranioplasty	100.00
15	Trephine and/or craniotomy for sub- dural hematoma	125.00
16	Extradural hematoma	125.00
17	Brain abscess	125.00
18	Craniotomy for tumor	150.00
19	Craniotomy for cerebral scar, aneurysm and similar major lesions	150.00
20	Resection of encephalocele	75.00
21	Craniotomy for congenital hydro- cephalus	75.00
22	Pre-frontal lobotomy	125.00

OBSTETRICS

6090	Delivery of child or children and im- mediate postnatal care—in home, clinic, or hospital—normal or forceps—\$	50.00
6002	Caesarean Section	100.00
10	Abdominal operation for extra uterine pregnancy	100.00
11	Miscarriage under four months of pregnancy—spontaneous	20.00
12	Miscarriage, requiring D & C	35.00
	Obstetrical consultations (individual consideration)	\$10.00—50.00

ORTHOPAEDIC

Head and Neck

7001	Wry neck (torticollis)	\$ 75.00
2	Cervical ribs, removal of (or scalenotomy)	50.00
3	Skin plasty to release contractures	75.00
10	Osteomyelitis of jaw	75.00
11	Osteomyelitis of skull	75.00
12	Bone graft, jaw	125.00
20	Fracture, cervical spine a. simple	50.00
21	b. complex	100.00

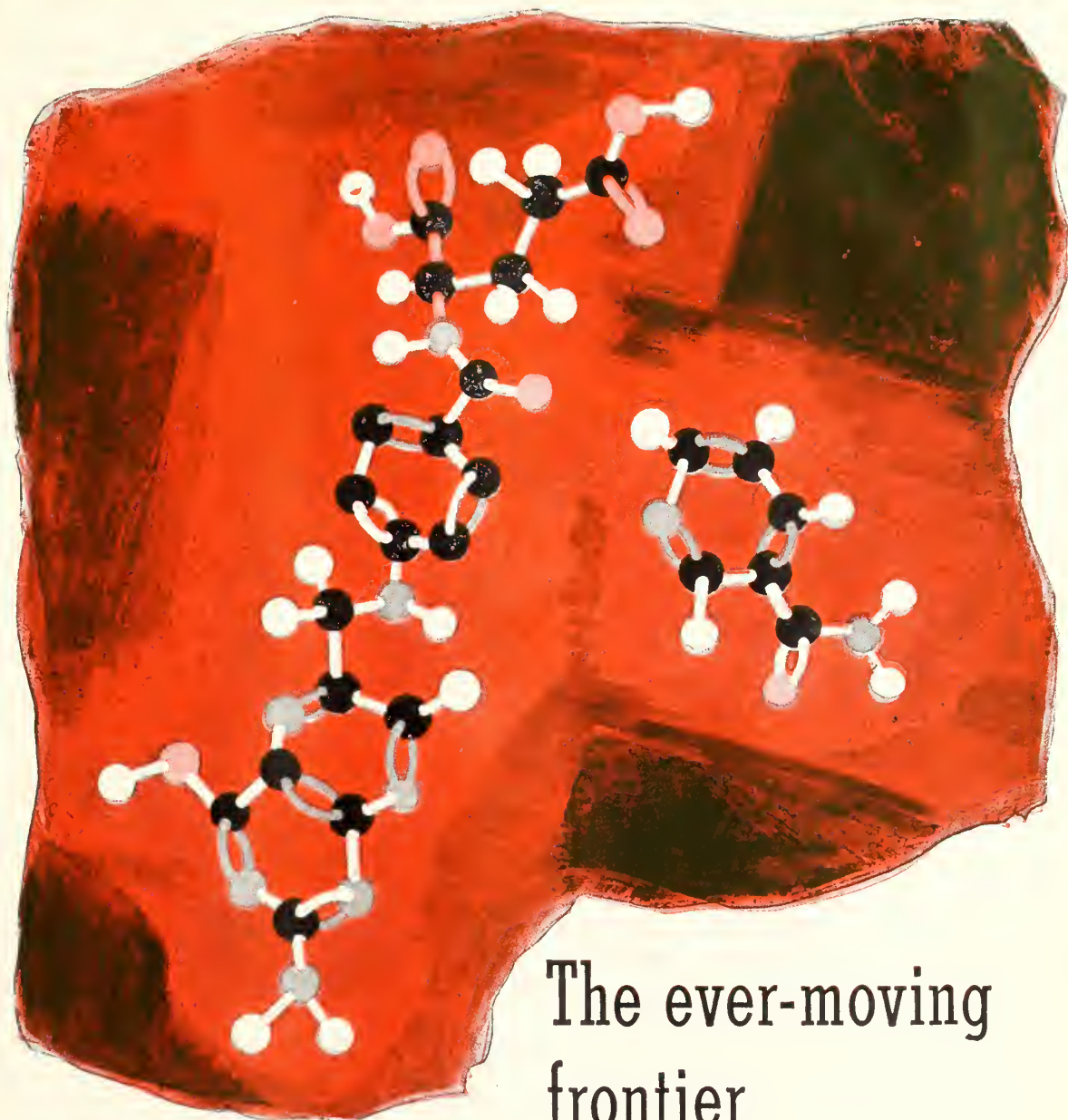
22	Fracture jaw, upper	25.00
23	open	50.00
24	lower	35.00
25	open	75.00

Shoulder, Arm, and Chest

7101	Open reduction, old dislocation	125.00
2	Habitual dislocation of shoulder (Nicola, etc)	100.00
3	Osteotomies of humerus	125.00
	Birth palsy, shoulder and arm and forearm, combined	
4	a. With surgery (Sever, etc.)	100.00
5	b. Without surgery	50.00
10	Arm—chest adhesions, above elbow ...	100.00
11	Arm—chest adhesions, including fore- arm	150.00
12	Non-union humerus or clavicle (bone graft)	150.00
13	Tenotomies (or tendon plasty)	75.00
14	Shoulder resection or arthrodesis	150.00
20	Osteomyelitis of clavicle, scapula or ribs (sequestrectomy)	35.00
21	T. B. Shoulder without operation	50.00
7122	Osteomyelitis of upper extremities (sequestrectomy)	50.00
23	Dislocation sternoclavicular joint and acromioclavicular joint — open re- duction, etc.	100.00
24	Reduction, closed, dislocated shoulder..	35.00
25	a. With fractured tuberosity	50.00
26	b. With fractured humerus—closed ..	50.00
27	—open ..	100.00
30	Clavicle fracture—closed	25.00
31	—open	30.00
32	Rib fracture, one or more	15.00
33	Sternum	15.00
34	Scapula (shoulder blade)	15.00

Elbow

7201	Elbow resection or arthrodesis	100.00
2	Elbow arthroplasty or reconstruction..	100.00
3	T. B. elbow with operation (resection or fusion)	100.00
4	Flexor transposition	75.00
5	a. Resection of head radius	50.00
6	b. Osteotomies of radius or ulna or both	75.00
7	c. Removal of piece of bone from joint for increase of motion — arthrotomy elbow	75.00
10	Open reduction, fractured elbow	100.00
11	Colle's fracture—a. If manipulated	50.00
12	b. Undisplaced	30.00
20	Ulna, fracture—a. Undisplaced	25.00
21	b. Closed reduction	50.00
22	c. Open reduction (or compound)	75.00
30	Radius, fracture—a. Undisplaced	25.00
31	b. Closed reduction ..	50.00



The ever-moving frontier

Research on vitamin knowledge in the field of nutrition has come a long way since the early published researches of McCollum, Mendel and Funk. The science of nutrition is no longer the stepchild of medicine, nor the poor relation of agriculture. In particular, our understanding of the need for vitamins in human nutrition has enormously increased. Vitamins constitute in the aggregate the *sine qua non* for cellular respiration, reproduction, growth and repair.

For the past 25 years, biochemists have pressed forward a continually moving frontier of scientific discovery in the field of nutrition. In recent years, *Lederle* has been in the vanguard of this movement, its investigators being well known for their achievements with folic acid, pyridoxine, biotin, the pantothenates, liver extract, and allied substances. There will be no slackening in the efforts of this organization to uncover additional aids to better health and better living.

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32	c. Open reduction (or compound) ---	75.00	26	Coccygectomy -----	75.00
40	Ulna and radius fracture—			Hip and Thigh or Pelvis	
	a. Undisplaced -----	25.00	7501	Osteomyelitis of femur or pelvis with sequestrectomy -----	75.00
41	b. Closed reduction -----	75.00	2	Ununited fracture of femur with bone graft -----	150.00
42	c. Open reduction (or compound) --	100.00	3	T. B. hip or Perthes, without opera- tion—cast or brace -----	50.00
43	d. Bone graft, single bone -----	125.00	4	T. B. hip with operation (fusion) ----	150.00
44	both bones -----	150.00	5	Congenital dislocation of hip (closed reduction) -----	75.00
	Forearm, Wrist, Hand, Including Fingers		6	shelf or fusion, or open reduction ---	150.00
7301	Tendon transplant -----	100.00	10	Soutter fasciotomy -----	75.00
2	Tenotomy of pronator quadratus— pronator raditeres -----	50.00	11	Arthroplasty, hip -----	150.00
	Skin plasty—skin grafts:		12	Arthrodesis of hip -----	150.00
3	a. Wrist or palm of hand and fingers combined -----	75.00	13	Subtrochanteric osteotomy (femoral osteotomy, manipulation and plas- ters) -----	150.00
4	b. Fingers only -----	50.00	14	Tenotomy of adductors -----	50.00
10	Resection of wrist or arthrodesis -----	100.00	15	plus obturator neurectomy—(2) ----	100.00
11	T. B. wrist (fusion)—cast -----	100.00	20	Ober type fasciotomy—a. single -----	35.00
12	Club hands or osteoclasia, forearm bones -----	75.00	21	b. double -----	50.00
13	Closed correction of contractures, wrist and hand (post traumatic) ---\$35.00—75.00		22	Sacro-iliac arthrodesis -----	125.00
14	Syndactylism—each two fingers -----	50.00	23	Manipulation of hip and plaster -----	35.00
7315	Bone graft, radius or ulna -----	150.00	7524	Quadriceps plastic (Bennett operation) Slipped upper femoral epiphysis—	150.00
20	Amputation of finger (non-syndacty- lus), each -----	10.00	30	a. closed correction -----	75.00
21	Tenoplasty (repair severed tendons) (and/or nerves) -----	\$75.00—125.00	31	b. open correction -----	150.00
22	Joint resection, osteotomy or arthro- plasty, finger -----	75.00		(obstetomy and/or pinning)	
30	Carpal fracture—a. simple -----	30.00	40	Fractured hip, neck—a. closed -----	125.00
31	b. open -----	75.00	41	b. open -----	150.00
40	Metacarpal fracture—a. simple -----	15.00	42	Fractured hip—trochanteric—a. closed -	125.00
41	b. open (or com- pound) -----	25.00	43	b. open --	150.00
42	(each additional, 50% more)		50	Pelvis, fracture -----	60.00
50	Fingers, fracture—a. simple -----	10.00	60	Dislocation, hip—a. closed -----	50.00
51	b. open (or com- pound) -----	20.00	61	b. open -----	150.00
52	(each additional, 50% more)		70	Fractured femur (traumatic) a. closed -----	100.00
	Spine or Torso		71	b. open (or compound) ---	125.00
7401	Spinal fusion -----	150.00		Knee	
2	Spinal curvature—correction and fusion	150.00	7601	Knock-knee or bow legs (osteotomy) femur or tibia:	
3	T. B. Spine, without surgery (see casts) without fusion -----	50.00		a. single -----	50.00
4	Osteomyelitis, sequestrectomy and drainage -----	100.00	2	b. double -----	75.00
10	Dislocation, spine—closed reduction and cast -----	100.00	10	T. B. of knee joint with plaster or brace	75.00
11	open reduction plus fusion -----	150.00	11	T. B. of knee with resection of joint or fusion -----	150.00
12	(or minus fusion) -----	125.00	12	Tendon transplantation -----	125.00
20	Tendon or fascial transplant -----	150.00	13	Tenotomy of hamstrings -----	75.00
21	Marie-Strumpell, per case (correction; casts; physio; x-ray therapy) -----	100.00	14	Arthroplasty -----	150.00
22	Fracture—closed reduction and cast ---	100.00	20	Removal or repair of cartilage or loose body (dissecans) -----	85.00
23	open reduction -----	150.00	21	Correction of flexion— cast only (one knee) -----	75.00
24	Fracture of sacrum or coccyx -----	50.00	22	(both knees) -----	125.00
25	Laminectomy (2 surgeons) and fusion -----Ind. cons.		23	surgery with cast (one knee) -----	125.00
			24	surgery with casts (both knees) -----	150.00
			30	Fractured patella— a. closed (without displacement) --	25.00



if she is one

of your patients...

The farm housewife whose work is truly never done may find that the distressing symptoms of the climacteric make the smallest chore an arduous project. She depends on your help to resume normal efficiency in the performance of her daily tasks as well as to maintain a positive outlook during this trying period.

"Premarin" offers a solution. Many thousand physicians prescribe this naturally-occurring, oral estrogen because...

1. Prompt symptomatic improvement usually follows therapy.
2. Untoward side-effects are seldom noted.
3. The sense of well-being so frequently imparted tends to quickly restore the patient's confidence and normal efficiency.
4. This "Plus" (the sense of well-being enjoyed by the patient) is conducive to a highly satisfactory patient-doctor relationship.
5. Four potencies permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).



While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estragens...estradiol, equilin, equilinenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.

"PREMARIN"



ESTROGENIC SUBSTANCES (WATER-SOLUBLE)
also known as CONJUGATED ESTROGENS (equine)

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31	b. open -----	100.00		a. cast and wedging -----	\$25.00-45.00
40	Synovectomy -----	100.00	36	b. reconstruction, single -----	100.00
41	Baker's cyst, excision -----	50.00	37	c. reconstruction, double -----	150.00
42	Epiphyseal drilling and plugging (each) -----		40	Amputation of toe -----	10.00
	tibia and femur -----	25.00	41	Tendon transplantation of foot (alone) -----	50.00
43	fibula -----	15.00	42	Tenoplasty of foot or toe (repair of severed tendon, one or more) -----	25.00
44	Burn contracture, release and graft -----	\$50.00-100.00	43	Operative correction of bunion:	
45	Popliteal neurectomy (Stoffel's)			a. single -----	50.00
	a. unilateral -----	35.00	44	b. double -----	75.00
46	b. bilateral -----	50.00	50	Wedge osteotomy or resection -----	50.00
Legs			51	Skin plasty or skin grafts, foot --	\$35.00-50.00
7701	Osteomyelitis tibia, single--		52	Drop foot bone block, operation, alone -----	75.00
	a. incision and drainage -----	25.00	53	Posterior capsulotomy, when separate procedure -----	25.00
2	b. sequestrectomy -----	50.00	54	Excision, toe nail (in-grown) each ---	5.00
3	Osteomyelitis, patella & fibula--		60	Scaphoidectomy--a. single -----	35.00
	a. incision and drainage -----	25.00	61	b. double -----	60.00
4	b. excision or sequestrectomy -----	50.00	62	Clawfoot (complete with toe surgery) -----	125.00
10	Ununited fracture or tibia, bone graft of -----	150.00	63	Hammer toe (alone) each -----	15.00
11	Osteoclasia tibia--a. single -----	50.00		Tarsal or metatarsal fractures or dis- location (each):	
12	b. double -----	75.00	64	a. closed (each additional 50% more) -----	20.00
7713	Cartilage excision, knee -----	85.00	65	b. open (or compound) -----	35.00
14	Dissecans, osteochondritis -----	85.00		(each additional 50% more)	
15	Ligament reconstruction (knee) -----	125.00	7870	Toe, a. closed -----	10.00
20	Fractured tibia--		71	(each additional 50% more)	
	a. closed -----	75.00	72	b. open (or compound) -----	20.00
21	b. open (or compound) -----	100.00	73	(each additional 50% more)	
22	Fractured fibula -----	25.00	Miscellaneous		
23	Fractured tibia and fibula, shaft -----	75.00	7901	Amputations:	
Ankle and Foot				a. Thigh--above trochanter -----	125.00
7801	Potts' fracture--		2	b. Thigh--below trochanter -----	100.00
	a. closed reduction and cast -----	50.00	3	c. Leg, below knee -----	75.00
2	b. open reduction -----	75.00	4	d. Forefoot -----	50.00
3	Cotton fracture--		5	e. Shoulder (scapulo-humeral) -----	150.00
	a. closed reduction and cast -----	50.00	6	Shoulder (humeral) -----	100.00
4	b. open reduction -----	100.00	7	f. Below elbow (forearm) -----	75.00
10	Ankle fusion -----	125.00		g. Finger or toe (each) -----	10.00
11	Triple arthrodesis (with transplanta- tion) -----	125.00	8	h. Metacarpal or metatarsal -----	50.00
12	Sprain--strapping -----	15.00	10	Manipulation of joint adhesions, each (major joints) -----	15.00
13	cast -----	35.00	11	Removal of bone tumors other than simple exostosis -----	100.00
20	Achilles lengthening--		12	Extensive skin grafting, including tube grafting -----	100.00
	a. unilateral -----	25.00	13	Neurolysis, ulnar, radia, etc. -----	75.00
21	b. bilateral -----	35.00	21	Ganglion, wrist -----	35.00
22	Astragelectomy (ankle bone) -----	50.00	22	Exostosis (one or more) -----	50.00
23	Os calcis--a. simple -----	50.00	23	Biopsy -----	25.00
24	(heel)--b. open (or compound) -----	75.00	24	Spinal puncture -----	10.00
31	T. B. or osteomyelitis, sequestrectomy and drainage -----	35.00	UROLOGY		
32	Plantar fasciotomy (alone) -----	25.00	Kidney and Perinephrium		
33	Arthrodesis--subastragalar complete (Hoke foot stabilization) -----	100.00	8001	Adrenalectomy or exploration -----	\$150.00
34	Clubfoot, congenital (single or double) casts or Dennis Brown splints--each visit -----	7.50	2	Incision and drainage, perinephric abscess -----	75.00
35	Correction for flatfoot;				

3	Excision, renal fistula	50.00
4	Renal sympathectomy	100.00
10	Decapsulation, unilateral	100.00
11	bilateral	150.00
12	Nephrectomy or heminephrectomy	150.00
13	Nephrolithotomy	150.00
14	Nephrostomy	100.00
15	Nephropexy (includes management of anomalous vessels)	100.00
20	Symphysiotomy and nephropexy (horseshoe kidney)	150.00
21	Pyelolithotomy	125.00

Ureter

8101	Incision and drainage, peri-ureteral abscess	75.00
2	Plastic repair, ureteropelvic juncture	150.00
3	Ureteropelviostomy	150.00
4	Ureterocystostomy	150.00
5	Ureter, anastomosis of	150.00
6	Ureterosigmoidostomy	150.00
8107	Ureterostomy, cutaneous	100.00
8	Ureterolithotomy	125.00
9	Ureterotomy (tumor or stricture)	125.00

Bladder

8201	Cystotomy	75.00
2	Cystolithotomy	100.00
3	Cystotomy, fulguration of tumor	100.00
4	Cystotomy, implantation of radium (radium not included)	100.00
5	Cystectomy, partial resection	100.00
6	Cystectomy (including ureteral trans- plants)	150.00
7	Diverticulectomy	100.00
8	Vesicovaginal fistula	100.00
9	Vesicorectal fistula	100.00

Prostate

8301	Incision and drainage, abscess	75.00
2	Prostatomy, for stone	75.00
3	Prostatectomy, perineal	150.00
4	Prostatectomy, suprapubic (includes cystotomy)	150.00
5	Prostatectomy, transurethral	100.00
6	Repair, recto-urethral or perineal urethral fistula	100.00

Seminal Vesicles

8401	Incision and drainage, abscess	75.00
2	Seminal vesiculectomy	100.00
3	Vasoligation or vasotomy	25.00

Crotum

8501	Hydrocele, excision	50.00
2	Hydrocele, tapping	5.00
3	Epididymectomy or epididymotomy	50.00
4	Varicolectomy	50.00
5	Orchidectomy, unilateral	50.00
6	bilateral	75.00
7	Orchidopexy (includes hernioplasty)	100.00
8	Plastic for elephantiasis	100.00

Urethra and Penis

8601	Amputation, simple	50.00
2	radical	100.00
3	Biopsy	5.00
10	Circumcision, under 15	10.00
11	over 15	25.00
20	Dorsal slit—in office	5.00
	—in hospital	10.00
21	Excision penile urethral fistula	75.00
22	Meatotomy, urethral	10.00
24	Caruncle in female, excision	10.00
25	Prolapse of female urethra resection	35.00
30	Urethrotomy, external	75.00
8631	Urethrotomy, internal	25.00
32	Dilation of stricture	5.00
33	Incision and drainage, periurethral abscess	25.00
34	Extravasation (without cystotomy)	50.00
35	Urethroplasty, stage operation	150.00
36	Plastic repair of chordee	50.00
40	Fulguration of warts—in office	5.00
	—in hospital	10.00
41	Fulguration of Caruncle	
	—in office	5.00
	—in hospital	10.00

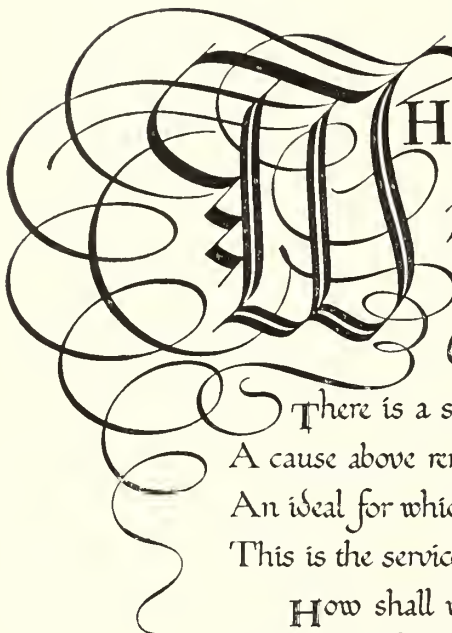
Cystoscopy, Diagnostic and Operative

8701	Observation cystoscopy, initial	10.00
2	subsequent (limited to \$30.00 each adm.)	5.00
3	Cystoscopic ureteral catheterization and/or dilation	25.00
4	Extraction of ureteral stones	50.00
5	Litholopaxy	75.00
10	Fulguration, ulcer or papilloma	25.00
11	Resection and fulguration of car- cinoma	75.00
12	Biopsy of tumor	25.00
13	Implantation of radium (radium not included)	25.00
14	Ureteral meatotomy	25.00
15	Resection urethral polyps	25.00
16	Removal of foreign body (not stone)	50.00

MISCELLANEOUS (SURGICAL PROCEDURES
ONLY)

9001	Superficial abscesses and boils—incision and drainage	\$ 3.00
2	Other—deep-incision and drainage— individual consideration—maximum	20.00
3	Deep cervical abscesses—individual consideration maximum	50.00
10	Carbuncle—excision	30.00
11	Ulcer—excision	10.00
12	Pinch grafts	Ind. Cons.
13	Other skin grafts	Ind. Cons.
14	Suturing of wounds	Ind. Cons.
20	Cysts, sebaceous, removal	10.00
21	Dermoid cysts	Ind. Cons.
22	Glands, superficial removal	7.50

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DHO shall measure devotion, or put a price
on sacrifice?
Who shall assess the long war against
the power of Death?
Or set a sum upon the gift of Life?

There is a service beyond the measure of a fee.

A cause above remuneration.

An ideal for which there is no price.

This is the service...the cause...the ideal...of the American Doctor.

How shall we reckon it, and by what formulae?

How much for the laughter of a little child rescued out of crisis?

What's the cost of discouragement?

Who can pay for a sleepless night?

Name the price of a cure!

AMERICAN DOCTOR

rendered..."

There is no algebra for it, no scribble of figures, no proper value.

For this is a service as large as life, and as manifold.

It is a soldier crying in agony on a thousand battlefields.

It is the terrible word "Why?" under the surgeon's probe.

It is the end of pain.

It is Hope.

It is the lonely, unending quest for knowledge.

It is the fight against ignorance, sloth, superstition.

It is the dumb, unspeakable joy in the eyes of a parent.

It is the rock of grief.

It is cold rain and pounding storm and bone-weariness and the new-born babe gasping its first breath in the grey dawn.

It is all this, and the quiet glory of the job done,

Dedicated to service—in the name of Mercy

And the common brotherhood of man.

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Dissection of glands of neck for cancer (see neck No. 3303) -----	100.00	Hip pinning procedure -----	25.00
30 Toe nail, ingrown, removal -----	10.00	Nose -----	10.00
31 Pericardium, paracentesis -----	10.00	Facial bones -----	15.00
32 Pneumolysis -----	50.00	Sinuses -----	15.00
33 Cardiotomy -----	Ind. Cons.	Mastoids -----	15.00
34 Abdomen—paracentesis -----	7.50	Jaw -----	10.00
35 Mucosa, excision of redundant -----	10.00	Skull -----	15.00
36 Aspiration of joint -----	10.00	Encephalography -----	25.00
OTHER MISCELLANEOUS PROCEDURES		Spine, one section -----	15.00
9101 Blood transfusions—		Spine, two sections -----	20.00
—Direct from donor to patient -----	25.00	Spine, entire -----	25.00
2 —Infusion (over 2 yrs. of age) -----	5.00	Myelography -----	10.00
3 —Infusion (under 2 yrs. of age) -----	10.00	Ribs -----	10.00
DIAGNOSTIC X-RAY		Pelvic encephalography -----	20.00
INJURY OR ACCIDENT CASES ONLY		Chest -----	10.00
Finger or toe -----	\$ 5.00	Bronchogram -----	20.00
Hand or foot -----	7.50	Eye, Sweet localization of foreign body or equivalent -----	25.00
Extremity, other than above -----	10.00	Urinary Tract -----	10.00
Shoulder -----	10.00	Pyelogram -----	15.00
Pelvis -----	10.00	Fluoroscopic aid in reduction of fracture -----	5.00
Hip -----	10.00	Fluoroscopic examination when no films are made -----	5.00
		X-Ray fees of over \$25.00 for one case will receive individual consideration.	

ABSTRACTS

Friedman, M. H. F. and Haskell, B. F.: Treatment of Non-specific Ulcerative Colitis for One Year with Extracts of Intestinal Mucosa.

(Gastroenterology 11:833-842, Dec., 1948)

The authors suggest that non-specific ulcerative lesions of the bowel may be due to the absence of an intrinsic factor normally associated with the intestinal mucosa and have treated 27 patients with intestinal extracts for a period of one year or longer. All had proved refractory to other therapies.

A crude extract of intestinal mucosa was used in a daily dose of 50 to 100 grams in divided portions. With improvement this amount was reduced to what was considered a maintenance dose.

Distinct evidences of improvement were shown by 24 of the 27 patients after 2 to 5 weeks of treatment. In patients with frequent bowel movements the first sign of improvement was reduction in frequency, followed by a disappearance of blood and decrease of mucus from the stool, and finally a return of stool consistency towards normal. The rectosigmoid showed decrease in friability, gradual healing of the ulcers, disappearance of edema, absence of mucus, and a return of the normal colon and elasticity of the mucosa. The mucosal changes were noted only several weeks after symptomatic improvement was evident. Relapses during treatment were infrequent,

of short duration and usually in connection with upper respiratory tract infections. Withdrawal of treatment or substitution of a placebo, or use of intestinal extracts prepared by a different method resulted in a relapse with remission recurring on resumption of treatment with an effective extract. The authors found that patients less severely affected responded more promptly.

Terrell, Jr. C. O., and Hoar, C. S.: Streptomycin In the Treatment of Hemophilus Influenzae Laryngotracheobronchitis; The J. of Ped.; 34:139; February, 1949.

The authors present four cases of H. influenzae laryngotracheobronchitis in young infants successfully treated with streptomycin whose ages ranged from nine weeks to six months with two of them being four months of age.

The history and physical in all four cases were similar. The present illness began anywhere from 4 days to 1 week prior to admission and was characterized by an upper respiratory infection with rhinitis, nonproductive cough, anorexia, and low-grade fever. These symptoms in all cases progressed in severity and on admission the infants exhibited fever, rapid, wheezing respiration, and cyanosis. Physical examination revealed dyspnea with markedly increased

respiration, elevated temperature, inflamed pharynx, rales over both lung fields, and a white count ranging from 10,700 to 16,750. A throat culture was taken immediately. In all but one case the initial report showed *H. influenzae*. In this case, the infection was of a mixed type but a subsequent culture revealed the *H. influenzae*.

The immediate treatment consisted of continuous oxygen, penicillin 15,000 units intramuscularly every 3 hours, and a vapor tent. As soon as the cultures were reported as positive for *H. influenzae*, streptomycin

was started with 50 mgm. intramuscularly every 3 hours. Within 12 hours the infants' respirations were markedly improved and the temperatures fell by crises shortly afterwards. The infants were discharged anywhere from the 6th to the 10th hospital day.

The authors suggest that streptomycin be given immediately to all cases of laryngotracheobronchitis occurring in young infants and continued until the throat culture reveals a nonsusceptible organism. The authors have found no ill effects from streptomycin given for such a short time.

PUBLIC HEALTH NEWS

4 CARDIAC CLINICS PLANNED FOR THE STATE

Plans for the establishment of four regional cardiac clinics at focal points in the state were made at a recent meeting of the Board of Directors of the South Carolina Hospital Association. Tentative plans were made to establish other clinics as fast as money is made available through contributions to the Association. The Board also made available an annual fellowship in cardiology at the Medical College of South Carolina to be awarded to a physician in the state selected by the Medical College.

The Board of Directors of the South Carolina Heart Association consists of one physician from each of the nine medical districts in the state, and three lay members-at-large. There are no local chapters, although 19 counties were organized this year for the purpose of fund raising only. Next year all 46 counties will be organized for that purpose.

Members of the Board of Directors are: Dr. John A. Boone, president; Dr. Izard Josey, vice president; Angus E. Bird, treasurer; H. M. McElveen, executive secretary; Dr. O. Z. Culler, Dr. Hugh Smith, Dr. Charles White, Dr. W. J. Nelson, Dr. S. H. Shippey, Dr. W. L. Pressly, A. L. M. Wiggins, Dr. W. R. Mead, and Wilton Hall.

CHARLESTON TO BE HEART RESEARCH CENTER

Dr. Ben F. Wyman, State Health Officer, has been notified by the U. S. Public Health Service that Charleston has been selected as one of three sites in the United States where research centers for heart diseases will be established. Other heart centers will be in Massachusetts and Indiana.

The heart disease program will consist of fact-finding and follow-up activities for cardiac cases treated by the physicians of Charleston. The heart center will

be operated by the U. S. Public Health Service and local public health officials, but the program to be followed will be determined by the doctors of Charleston.

Patients will not be treated or diagnosed at the heart center, but will be studied over a period of time to determine the effects of treatment, diet and other factors recommended by the Charleston doctors associated with the program.

Before the decision was made to establish the demonstration unit in Charleston, it was necessary to gain the approval of the State Board of Health, the South Carolina Medical Association, the Medical Society of South Carolina (at Charleston) and the Charleston County Board of Health.

The heart center will be staffed with heart specialists, nurses, educators, and other personnel. South Carolina and Charleston were selected over a number of other states competing for the heart center.

NEWS ITEMS

Dr. Hillyer Rudisill, Jr. has opened his office for the practice of radiology at 145 Rutledge Avenue, Charleston.

Dr. J. Harvey Atwill of Columbia, and Dr. Harold L. Sanders of Greenville have volunteered for duty with the armed forces.

Dr. John R. Harvin has opened an office in Columbia for the practice of pediatrics. Dr. Harvin formerly practiced in Sumter.

Dr. W. Cyril O'Driscoll has been promoted to professor of anatomy at the Medical College of South Carolina. Announcement of his promotion from associate professor to a full professor was made by the Medical College Dean, Dr. Kenneth M. Lynch.

DEATHS

ROBERT SPANN CATHCART

Dr. Robert S. Cathcart, noted surgeon of Charleston, died at his home on April 29 at the age of 77. He had been seriously ill for several weeks.

Dr. Cathcart was born in Columbia, September 25, 1871. He attended the Columbia schools and the school of pharmacy of the University of South Carolina and received his degree in pharmacy in 1890. Three years later he was graduated from the Medical College of South Carolina. After a period of internship in the hospitals of Charleston, he engaged in the general practice of medicine for fourteen years before going into surgery. Dr. Cathcart actively practiced medicine for over fifty-five years.

Surviving Dr. Cathcart are his widow, the former Miss Katherine Morrow of Birmingham; two sons, Robert S. Cathcart, Jr., and Dr. Hugh Cathcart, both of Charleston; two daughters, Mrs. William S. Stevens of Charleston, and Mrs. William G. Hamm of Atlanta.

LIONELLE DUDLEY WELLS

Dr. Lionelle D. Wells, Sr., 64, prominent physician of Holly Hill, died at Roper Hospital in Charleston, May 18, after an illness of several weeks.

Dr. Wells was born at Wells, May 26, 1884. He received his education in the schools of Orangeburg County and was graduated from Furman University in 1906. Four years later he was graduated from the Medical College of South Carolina. After further study at the medical school of the University of New York, Dr. Wells settled at Holly Hill where he was living at the time of his death.

Dr. Wells is survived by his widow, the former Mary Hughey of Greenwood; two sons, Dr. L. D. Wells, Jr. of Little Rock, Arkansas, and M. H. Wells of Holly Hill; three daughters by a previous marriage.

BIRTHS

Dr. and Mrs. James L. Hughes of Greer have announced the birth of a son, Richard Perry, March 21, in Greenville.

Dr. and Mrs. Henry W. Herbert of Florence have announced the arrival of a son, Henry Williams Herbert, Jr., May 14, in Florence.

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The Journal

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VOLUME XLV

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NUMBER 7

One Hundred and First Annual Session South Carolina Medical Association

MAY 17, 18, 19, 1949

OCEAN FOREST HOTEL

MYRTLE BEACH, S. C.

HOUSE OF DELEGATES

May 17th—11:00 A. M.

Presiding—Dr. R. B. Durham, President.

Call to Order.

Report of Credentials Committee, Dr. J. C. Sease.

DR. SEASE:	41 Delegates
	7 Past Presidents
	12 Members of Council
	—
Total	60 Delegates Registered

The Chair: Inasmuch as we have a quorum, I will now declare the South Carolina Medical Association open for business on its 101st year.

The first report is that of Mr. M. L. Meadors, Director of Public Relations and Counsel for the Association.

REPORT OF THE DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

The work of our office since the last annual meeting has followed the same general line as in previous years. There has been a wide and rapid expansion of the Public Relations service, due primarily, of course, to the renewed activity on the national legislative front in the effort to enact compulsory health legislation. It has been necessary to devote more and more of our time to the promotion of efforts to interest the doctors generally, throughout the State, and to keep abreast of the activities in the same general direction in other States.

Relations With the Public

Last fall, after obtaining the authority of Council, we undertook the organization of a Public Relations Committee in each Medical Association District. These Committees were headed by the Councillor of the District, and included within their membership one member from the Medical Society of each County in the District. These Committees served as the nucleus for disseminating information originating in our office in Florence to the doctors within the District, regarding public relations and legislative matters. They also were intended as the spearhead of any effort to promote or oppose prospective legislation in the General Assembly. While circumstances did not require any extensive use of these Committees during the past few months, they have, in a few instances, served in good stead. The important thing is that the organization is now intact and is ready to serve on a moment's notice.

State Legislative Activities

The 1949 session of the General Assembly of South Carolina has differed from that of the past few years in that there has been no major issue before the legislative body in which the members of the Medical Association were vitally interested. For the first few weeks of the Session we made regular trips to Columbia, actually spending more time there than in previous years. There were many new members in both the House and Senate with whom we needed to become personally acquainted. This was done and we believe to good advantage. It will be recalled that, at the very beginning of the Session, the House of Representatives underwent a drastic reorganization so far as their Committees were concerned. The 24 Standing Committees were consolidated and reduced to 8 in number. The Medical Affairs Committee was dispensed with, and the matters previously handled by that group were thereafter referred to the 27-man Committee on Military and Public Affairs.

With possibly one exception, the only Bills before the Legislature this year in which the Association has had any real interest, were those dealing with the practice of Naturopathy. The exception was the Bill (S.123) introduced by Senator Wallace, and others, to appropriate \$5,000,000 for the building of hospitals and health centers. The measure was amended and much debated, but had failed to pass by the end of the past legislative week.

The Naturopaths

For the past several years there has been growing dissatisfaction throughout the State regarding the activities of the Naturopaths. The trouble is much worse in some sections than in others. During the summer of 1948, not long after the last annual meeting, definite complaints were made and there was some suggestion that the State Association had not performed its full duty to the public in an effort to curb this growing activity.

It will be recalled that during the Sessions of the Legislature in the past years, we kept closely in touch with proposed legislation regarding these practitioners, and made a determined effort to bring about some improvement in the situation. A Concurrent Resolution, adopted in the closing days of the Session in 1948, providing for an investigation by the Board of Naturopathic Examiners was the only thing concrete, however, which we were able to accomplish. This seemed to be as far as our office had any right to go in con-

nection with the matter without some direct authorization from the House of Delegates or the Council. Accordingly, in November of last year, after a brief review of the situation, I asked Council for instructions as to what steps, if any, should be taken in regard to the matter.

In response to that request, Council appointed a Committee, consisting of Dr. Howard Stokes of Florence, Chairman; Dr. Lawrence P. Thackston, Orangeburg; Dr. Roderick MacDonald, Rock Hill; Dr. W. Wyman King, Batesburg; Dr. A. W. Browning, Ellmore; and your Director.

This Committee studied the matter carefully, taking into consideration the efforts which had already been made, the apparent complete inability to get through the General Assembly, any legislation which would serve as a direct curb upon the authority which had been acquired by the Naturopaths through legislation enacted in 1937, and amended in 1941. The result of the Committee's deliberations was a recommendation to Council that the Association endorse and sponsor the enactment of a Basic Science Law in South Carolina similar to that in effect in several other states. A proposed Bill was drafted. Council considered the matter briefly and directed the Committee to confer with the State Board of Medical Examiners and report back to Council the result of the conference. Council later decided that such action should not be taken without the approval of the House of Delegates at this annual meeting. Therefore, of course no effort was made to have a Basic Science Law introduced.

Council was of the opinion that our efforts should be concentrated upon the passage of a Bill to repeal the provisions in the present statutes which authorize the practice of obstetrics and gynecology by Naturopaths and their use of biologicals. Such a Bill was immediately introduced and referred to the Committee on Military and Public Affairs. That Committee promptly referred it to a sub-committee consisting of Representatives Richardson of Georgetown, Blease of Saluda, and McChesney of Spartanburg. Despite efforts both direct, and through the members of the Public Relations Committees in these Counties, and otherwise, no favorable action was obtained from the sub-committee. In fact, no action whatever has been taken, and our latest information, obtained indirectly, was to the effect that the sub-committee did not intend to act at the present session. There was reason to believe that two members of the sub-committee would be favorably disposed to the Bill, but that hope did not materialize.

An identical Bill was introduced in the previous General Assembly in 1947. It never left the House of Representatives, in which body it was introduced. If such a Bill could be passed by the House of Representatives, there is little likelihood that it could pass the Senate as presently constituted.

The most effective step was the Concurrent Resolution referred to above, and passed by the General Assembly in 1948. Although the Resolution was drastically changed from the form in which it was originally offered, the results were far better than expected. Although we had been unable to secure passage of the Resolution so as to provide for an investigation by an impartial joint Legislative Committee, the evidence at the Hearings and the determination of the effort made at that time, seems to have been sufficient to convince these practitioners that they would have to take steps to improve their standing if they expected to continue to operate.

Accordingly, last summer, pursuant to the Resolution, the Board of Naturopathic Examiners notified all of their practitioners who had been licensed in this State through reciprocity, to show cause why their licenses should not be revoked. Hearings were held

at the Jefferson Hotel in Columbia, and 64 licenses were revoked with authority to the licensees to take re-examinations by the Board. As a result of these re-examinations, licenses were reissued to eight Naturopaths, resulting in a net decrease of 56 in the number of these practitioners, as a result of the Resolution. This is the information obtained from the official report of the Board of Naturopathic Examiners to the General Assembly at its opening in January of this year. Examinations by the Board are held twice a year and, of course, the number will again be increased.

As a further result of the investigation, the Board of Examiners sponsored and promoted passage of a Bill to expand and more clearly define their authority to revoke licenses of their practitioners. The provisions of this Bill were generally good. They were designed to give the Board fuller powers to get rid of undesirable, and unqualified practitioners, which powers, if properly exercised by the Board, should result in a vast improvement in the situation as it now exists.

As originally introduced, the Bill, however, had one provision which it should not have included. This paragraph would have repealed the proviso now in the statute, to the effect that "nothing contained herein shall be construed as authorizing any Naturopathic physician to practice materia medica or surgery." The proposed provision would have thus removed the only remaining safeguard. We discovered the paragraph and called it to the attention of the Committee when the matter came up for consideration. Mr. Merchant of Spartanburg, one of the co-authors of the Bill, readily agreed that it had no place in the measure, and by agreement it was stricken out, the Bill withdrawn and re-introduced as a Committee Bill. In that form it passed the House of Representatives on April 12th, and went to the Senate where it was referred to the Senate Committee on Medical Affairs. As late as May 12th, the Bill had not been reported out of that Committee.

Another Bill introduced in the House would have repealed all the laws authorizing the practice of Naturopathy in South Carolina. It was not reported out of Committee.

Early in the Session, and designed primarily for the purpose of curbing illegal practice by Naturopaths, there was introduced by Representative Jackson of Sumter, a Bill providing for the establishment of a general Licensing Board for the Examination of applicants to practice any branch of the healing art. It immediately aroused opposition among practically all of the professions affected. Upon careful study, it was evident that the Bill was not appropriate for South Carolina and, in fact, contained a number of undesirable and dangerous features. Representative Jackson, upon being interviewed, readily agreed not to press this measure, provided some other effort were made to deal with the situation.

Prepayment Medical Care

At the last annual meeting, Council referred the matter of prepayment medical care plans to a Committee consisting of Dr. J. Decherd Guess of Greenville, Chairman; Dr. W. Wyman King, Dr. J. Howard Stokes, and your Director, for the purpose of additional study and formulation of a plan to be put into effect in accordance with the report made at the annual meeting in 1948. Accordingly, the Committee met, reviewed the matter carefully, and decided upon the basic principles which should be followed in setting up such a plan in South Carolina. It was determined that in the beginning the coverage should be limited to surgical and obstetrical cases, should be on a combination service and indemnity basis, and sold to groups only.

These, and other recommendations of the Committee were submitted to Council at a meeting in January, and approved. Council then appointed eight physicians to serve on a committee to work out a tentative fee schedule, and at the same time, directed that committee to look further into the matter of selection of lay members of the proposed Board of Directors of the new Plan.

These directions of Council were carried out, and the proposed fee schedule, as agreed upon by the professional committee, was prepared in mimeographed form and mailed to each member of the House of Delegates previous to this meeting. All meetings of the original committee and of the tentative Board of Directors of the proposed Plan, have been attended by your Director and the mimeographed copies were prepared in our office.

Although Council, at the meeting in January authorized application to the Secretary of State for a Charter for the proposed corporation, this has not been done in view of the possibility of some subsequent change in the name, or structure of the organization. The matter of incorporation is very simple and can be completed within a few days, if the proposals are adopted at this meeting.

State Health Council

Under the direction of Dr. Harold S. Gilmore, Chairman, and the members of his Committee on Rural Health, the second state-wide Health Conference was planned and held at the Columbia Hotel in November, for the purpose of considering the Constitution and By-Laws of a permanent organization. The meeting was well-attended and keen interest was manifest. Those present represented numerous organizations in the State, both private and public, which are interested and active in the improvement of health and facilities of treatment.

At this meeting a proposed Constitution and By-Laws for the State organization, prepared in advance, were submitted, discussed in detail and adopted. Shortly afterward a Charter was obtained from the Secretary of State for the State Health Council of South Carolina, with Dr. Harold S. Gilmore as President, your Director as Secretary, and Mr. R. L. Dougherty of Columbia, as Treasurer. The Association contributed \$500 to the Council to assist in starting its work and preliminary plans are in the making for beginning this important phase of health work in South Carolina.

Southeastern Regional Conference

In November of 1948, cooperating with the Secretary of the Association, Dr. Julian Price, we assisted in arranging the program and carrying through the Southeastern Regional Conference on Medical Service which was held in Columbia. This Conference, held annually under sponsorship of the Council on Medical Service of the American Medical Association, previously had met in Atlanta.

The meeting last year was highly successful and brought favorable comment from most of those who attended, including a member of the Board of Trustees of the American Medical Association, and a member of its Committee on Rural Health.

At the request of Dr. Price, we undertook to arrange the program and secure the speakers for the afternoon session of the first day of the Conference. Secured for this session were: Mrs. Wilma B. Sledge, Social and Educational Director of the Mississippi State Farm Bureau Federation; Dr. William R. Pretlow of Warrenton, Va., who discussed medical and hospital prepayment plans, and Dr. R. V. Platon, of the Department of Pediatrics of the Medical School of Tulane University and a recognized authority because of his work at Tulane in the field of survey and analysis of the availability of medical services and facilities.

The correspondence and clerical work incident to the preparation for the Conference was handled through our office and our office secretary covered the stenographic assignment at the meeting. Doctors attended the Conference from most of the South-eastern States.

A. M. A. National Education Campaign

We have cooperated in every way possible with the American Medical Association in the current National Educational Campaign. The pamphlets which are to constitute a major portion of the media through which information is to be distributed, is just now beginning to come through. Our work in this connection will increase within the next few months. Material is to be mailed to the central office in each State for redistribution to the county medical societies and individual physicians in the State. The organization is set up to carry this into effect promptly, and distribution of the pamphlets already received has been commenced.

In January, Council directed the expansion of our public relations activities and authorized an additional sum of \$5,000 for expenditure during the current year for that purpose if so much of the amount should be necessary. As a matter of fact, a comparatively small amount of this sum has been expended thus far. Additions have been made to the clerical help in the office to take care of the expanded activity.

Since January, we have mailed regular, weekly news releases to all the papers in the State, approximately 80 in number, including both the dailies and the county papers appearing at weekly, or similar intervals. These releases have dealt principally with activities in the field of medical care, as it concerns the public generally. No attempt has been made to develop any series of releases on the scientific side of medicine. We have felt that what is indicated in the present situation is not the dissemination of medical advice through newspaper columns—this is adequately taken care of by the syndicated features—but that we should make the public conscious of the fact that the doctors are awake to their responsibility to the public and are endeavoring to discharge that responsibility in whatever way it may be possible to do so.

It has been impossible to check accurately upon the use of our news releases. We undertook to have the members of the Public Relations Committees in the various Counties to keep up with this phase of the matter and report to us, but have not had much response. There has been very good use of the material in the daily papers and some use at least in the county papers.

Early in the year there was organized a Speakers' Bureau from among the physicians in the State, qualified and willing to serve in this capacity. Again, we called upon the members of the Public Relations Committees to assist in obtaining speaking engagements before civic clubs and organizations of similar kind. The response has been fair. We have filled every request for a speaker and will continue to do so as far as possible. There is no denying the fact that additional engagements could have been filled by members of the Speakers' Bureau if the engagements could have been arranged. Most of the talks have been before the better-known service clubs, and the response has been, without exception, favorable, and in many instances, enthusiastic.

Efforts to work out a concerted series of radio programs have not been very successful. At first, the larger stations with wider radius were tried, and a number of them agreed to carry the programs, but, for various reasons were unable to work them into their

schedules. More recently, we have undertaken to carry out the same purpose with some of the stations restricted to more localized audience. This is being worked out and will be perfected within the near future.

Legal

Recently, we have been called upon to furnish legal advice in connection with matters arising in certain of the county medical societies. This, in one instance, has required considerable study of the statutes and decisions pertaining to the right of county societies to deny applications of physicians to membership, together with perusal of extensive records of court proceedings involving one such applicant. The matter is being presented to Council at the current session.

Exhibits

The sale of space to commercial Exhibitors at the annual meeting was again handled by our office. Thirty-five Exhibit Spaces were disposed of, for a total of \$2,810.00, all of which has been collected.

As an added attraction, to induce the doctors to visit the Exhibits, three valuable prizes are being given away by the Association. One chance on these prizes may be obtained by each physician from each booth visited. Only physicians are eligible. The drawing will be held at the banquet on Wednesday evening, and holders of the numbers drawn must be present to win.

General

We have continued to produce the Ten Point Program Department of the Journal of the Association, this Department comprising approximately 6 printed pages of the Journal each month. In doing so, we have undertaken to make available to the readers of the Journal, information of current interest with respect to the developments in the field of medical economics and legislation and public policy. Many of the articles carried have been original, while use also has been made of reprints from other Medical Journals and Publications of various sorts.

Issuance of the BULLETIN of the Woman's Auxiliary, likewise has continued quarterly, and with extremely gratifying response. Officers and members of the Auxiliary have written to us expressing their approval and appreciation of this activity on the part of the Association, following the issuance of each Bulletin. Following our plan of last year, the Bulletin for the current quarter, issued and mailed from our office last week, was made the Convention Number, and carried the program of the Woman's Auxiliary, now in session here.

In addition to the foregoing, two Legislative Bulletins were issued to the entire membership within the past few weeks, and preparations were made for issuance of additional Bulletins but developments in the Legislature did not warrant.

We have contributed also, monthly, during most of the year, a column of legislative news in the Pee Dee Bulletin, issued regularly by the Pee Dee Medical Society.

Cooperating on the Speakers' Bureau, your Director has made 15 talks on the subject of compulsory health insurance in as many different towns, including Spartanburg, Lancaster, Winnsboro, Myrtle Beach and Greenwood. Most of these were to civic clubs—Rotary, Kiwanis and Lions. The total number of engagements filled by the Speakers' Bureau to date is between 25 and 30.

In addition to the activities of your Director personally, the clerical staff of the office has been far more busily engaged within the past twelve months than at any time since the program was instituted. Beginning immediately after the annual meeting in Charleston last year, the bound volumes of the History

of the South Carolina Medical Association, by Dr. J. I. Waring of Charleston, were wrapped and mailed from our office to all members of the Association who had not received them at the meeting. Approximately 600 volumes were handled.

The clerical work in connection with the Directory last year, likewise was performed by our office secretary. It will be recalled that the Directory contained considerably more information than in former years. Questionnaires were first mailed to all the physicians in the State. The information received was then compiled and arranged in our office. The record of the numerous changes in the Journal's mailing list from month to month, has also been kept current by the secretary in the Public Relations office, who also did the mimeograph work on the various Reports submitted today.

Conclusion

From the foregoing, it will be observed that the activities of the office are by no means confined to those with respect to public relations. We have steadily accumulated a large amount of administrative work, which in the case of most State Associations, is performed by a staff considerably larger than that which we have employed.

Finally, we must call attention to the emphasis being put by the National organization on encouragement of the sale of health and hospital insurance. I cannot recommend too strongly approval of the proposed prepayment Medical Care Plan. For the past four years, we have constantly urged the importance of this step, and at present, South Carolina is the only State without some such voluntary plan.

Respectfully submitted,

M. L. Meadors,
Director of Public Relations
and Counsel

The Chair: Inasmuch as no recommendation is made, in connection with this report, it shall be received as information.

Report of the Secretary—Dr. J. P. Price.

REPORT OF THE SECRETARY TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Your Secretary submits herewith his report of the activities of the Association during the past year.

Membership

The membership of the Association last year was 1,105—a gain of 93 over the preceding year, and an all time high.

Finances

The finances of the Association are in a sound condition. The annual audit has been presented to Council and has been published in the Journal. This shows that in spite of the expenses of the Centennial Session last year and the additional cost of printing "A Brief History of the South Carolina Medical Association," there was an excess of revenue over expense of approximately \$3,000. Council has voted to put \$10,000 into the establishment of a Medical Service Plan, if such a Plan is created by this House of Delegates. We have sufficient funds in our current expense account to take care of this without disturbing our Reserve Fund which now stands at \$15,000.

Journal

The Journal has been published every month and effort is constantly being exerted to make it informative and readable. There has been a slight change in the front cover which we hope is acceptable. An added feature this year has been a series of cartoons depicting socialized medicine at work. These cartoons have been assembled in a small pamphlet and are available for the members of the Association to distribute to their patients if Council or this House of

Delegates so directs. Before such a plan is adopted, provision will have to be made for the cost of publication. They can be sold to physicians at cost—approximately one cent per pamphlet—or could be furnished to members by the Association. This latter course would be quite expensive. If each member wanted five hundred copies for general distribution it would cost the Association \$5,000.

The Annual Directory

The Annual Directory was greatly enlarged this year with the addition of pertinent information concerning each member. This entailed considerable secretarial work but we believe it was worth the effort. One thousand and seventy-eight names are listed—twenty-seven joined the Association after September 1, the date of publication. Of this number 1,041 furnished the information requested, while twenty-seven failed to answer the letters sent out.

The enlarged Directory was well received by the members of the Association. It was also popular with certain organizations and individuals outside of the Association—and it was sold to them at the cost of \$1.00 per copy.

County and District Societies

It is the opinion of your Secretary that the interest in medical meetings throughout the state has been higher than it has been for several years. Some of the smaller county societies are to be congratulated upon joining with neighboring county societies for monthly meetings. This not only makes for better scientific progress but also stimulates friendship and understanding amongst the physicians.

State Health Council

Under the leadership of Dr. Harold Gilmore and Mr. M. L. Meadors, the South Carolina State Health Council was organized last fall. This is one of the outstanding steps taken by our Association in its efforts to cooperate with other groups and organizations in promoting the health of our people. It is also a splendid example of good public relations. Dr. Gilmore will give his report today and we ask for him your hearty endorsement of the program outlined.

Medical Service Plan

After many months of study, consideration, and discussion, a special committee appointed by Council will present at this meeting a concrete proposal for the creation of a Medical Care Plan by this Association. The report will be presented by Dr. J. D. Guess, Chairman.

Your Secretary has participated in several of the meetings of the committee and can assure you that the members have taken their assignment with real seriousness, and have given unstintingly of their time and effort. Your Secretary feels it imperative that our Association organize such a plan at this time and hopes that the necessary groundwork will be laid today.

Public Relations

As shown in the report of Mr. M. L. Meadors, our Association has enlarged its activities considerably in the field of public relations. Regardless of how much is done through separate department, your Secretary is convinced that our efforts will never reach their full measure of effectiveness until every county medical society and every individual physician is taking an active part in the work. The saying may have become trite but it still holds true that the greatest force in public relations in the field of medicine is the individual practicing physician. And it is also true that poor scientific work, unethical conduct, or exorbitant

fees on the part of one physician can cause severe damage to the reputation of the profession at large.

Educational Program of The American Medical Association

During the past year the American Medical Association has inaugurated an intensive program aimed toward the education of the general public in the advantages of a voluntary system of medical care as opposed to the governmental compulsory system proposed by Mr. Truman and Mr. Ewing. To finance this campaign the House of Delegates of the American Medical Association levied an assessment of \$25.00 against each of its members. Our Council endorsed this campaign and instructed your Secretary to collect the assessments through the county medical societies and to forward them to the American Medical Association. This has been done and as of May 15, the sum of \$14,425.00 has been collected. This represents the contributions from 577 members. In addition, eight members sent their money directly to the American Medical Association—making a total of 585 who have paid. It is hoped that those members of our Association who have not sent in their \$25.00 will do so immediately.

Heading up the campaign for the American Medical Association is the firm of Whitaker and Baxter, a California public relations concern. Working with them in an advisory capacity and also as a liaison group between them and the individual state medical associations is a committee of fifty-three, composed of one member from each state and territorial association. Your Secretary has been privileged to serve as the representative of our Association on this committee. In this capacity your Secretary has had opportunity to see the blueprint for the campaign and to observe the progress which has been made. To some it might seem that the going has been slow, but when one considers the magnitude of the task in setting up and carrying on a nation-wide campaign of this type one is more than pleased with the progress which has been made. Even now, reports indicate a change in attitude on the part of many individuals and a striking number of non-medical organizations and associations are lining up with the forces opposing any system of medical care dominated by the government. It is our considered opinion that this trend will become more and more marked as the months go by until it will be impossible for anyone, even Mr. Truman, to saddle a system of compulsory health insurance upon the people of this country.

It is obvious, however, that the Federal government will enter the field of medical care through financial assistance to states and to those individuals who cannot make the necessary financial provision for their own medical needs. It is also obvious that non-profit voluntary hospital and medical service plans (Blue Cross and Blue Shield) will play a more and more important role in this program. For this reason, if for no other, it is essential that our Association develop immediately a Medical Care Plan.

Ten Point Program

In September 1944, our Association adopted a Ten Point Program to serve as a guide for our activities and to give to the people of South Carolina a simple statement as to our aims and policies. During the four and a half years which have elapsed, our Association has made definite progress along the lines laid down. A State Health Council is in existence, a state-wide hospital service plan (Blue Cross) is now functioning, a comprehensive survey of hospital facilities and needs has been made, an expansion program of the facilities of the Medical College is now under way, a loan fund for worthy students at the Medical College has been created, better understanding has been

established between our Association and other groups in the field of health—to mention the more concrete and specific attainments. Your Secretary would be the last one to argue that credit for these accomplishments is due solely to the work of our Association. What has been done has been through the cooperative effort of many organizations and individuals, but in every instance our Association has had a prominent and at times a leading role.

Proud though we may be of what has been done, it will avail us little in this changing world to stand still and put ourselves on the back. It is the part of wisdom to determine our present position and to re-align our sights on the problems which lie ahead. With this in view, Council requested your Secretary to prepare a revised draft of the Ten Point Program—a 1949 model, if you will—for the consideration of this House of Delegates and that the Director of Public Relations be instructed to give it as wide publicity as possible.

Conclusion

In conclusion your Secretary would like to express his thanks to those many individuals who have helped and encouraged him in his work during the past year. Particularly would he like to thank the officers of the Association, the members of Council, the chairman members of various committees, the secretaries of the county medical societies, the Director of Public Relations, and the Business Manager.

The work of the Secretary's office and the traveling and speaking which the Secretary is supposed to do has increased immeasurably during the past few years. Your Secretary has tried to do his work as best he could. If he has failed in many respects he begs that you charge it to lack of time not to lack of interest or intent.

Julian P. Price
Secretary

The Chair: You have heard the Secretary and Treasurer's report, do I hear a motion for adoption of this report?

(Motion for the adoption of the report was made by Dr. William Weston, Sr., seconded by Dr. W. T. Brockman; the motion was put and the "ayes" carried and it was so ordered.)

Now the Report of Council, Dr. O. B. Mayer.

REPORT OF COUNCIL

Mr. President and Members of the House of Delegates:

As set forth in the Constitution and By-Laws of the South Carolina Medical Association, Council has acted, during the past year, as a committee responsible for the supervision and publication of the Journal, as finance committee, as an executive committee between the regular meetings of the House of Delegates, and as a committee to consider all questions involving the rights and standing of members of the Association.

Council met on May 13, 1948, and as its first duty elected officers for the coming year as follows: Dr. O. B. Mayer, Chairman, Dr. L. P. Thackston, Vice-Chairman, and Dr. Julian Price, Editor of the Journal.

Council met daily during the past session, and due to the many vital problems that have arisen since then, Council has met in five special sessions, the minutes of which have appeared in various issues of the Journal. Council held its final annual meeting yesterday.

Twelve issues of the Journal appeared during the past year. Its standard has been well maintained and considerable effort was made to keep the members informed on current legislative trends. No adverse criticism of the Journal has been received by Council. Advertising patronage has continued popular.

The Treasurer's report indicates that a strong financial position is being maintained. Public Accountants Jaillette & Brunson attest to the accuracy of the statement. A copy of the audit appeared in the March 1949 issue of the Journal. An excess of \$10,000 was received from advertising. At the end of 1948 the audit showed a bank balance in excess of \$17,000 and a reserve fund of \$15,000.

The House of Delegates, at its last meeting, requested Council to study a prepayment medical service plan, and in accordance with this directive, Council took this matter up at its first special meeting. A representative from the A. M. A., who is an expert in prepayment medical insurance organization, and the director of the North Carolina plan were invited to be present. These gentlemen and other key men from the State Association met with the Council and gave valuable advice. After thorough discussion, a Committee was appointed consisting of Dr. J. D. Guess, Chairman, Dr. J. H. Stokes, Dr. W. W. King, and Mr. M. L. Meadors, to submit a plan for this activity. This Committee has made an extensive study, has discussed the matter fully with Council, and is presenting its report today. It is unanimously endorsed by Council.

In response to a letter from the Industrial Commission, a special committee of five was appointed to study the present Industrial Commission fee schedule and to make recommendations for revision where indicated. This Committee consisted of Dr. J. Warren White, Chairman, Dr. Roderick McDonald, Dr. Augusta Willis, Dr. Henry Hall, and Dr. Ed. F. Parker, and they will report to you today.

Following a request from Dr. Harold S. Gilmore, President of the State Health Council, our Council instructed the Treasurer to pay an amount up to \$500.00 toward the work of the Health Council.

Council considered the question of attempting to secure special State Highway automobile licenses with the letters "M. D." appearing thereon. It was decided that this matter be referred to the House of Delegates.

A communication received from the Women's Auxiliary relative to proposing a bill making diphtheria immunization compulsory for all children before entering school was received and discussed. This matter is referred to the House of Delegates for consideration.

The problem of naturopathy has been discussed by Council on several occasions. A Committee composed of Dr. J. H. Stokes, Chairman, Dr. L. P. Thackston, Dr. Roderick McDonald, Dr. W. W. King, Dr. A. W. Browning, and Mr. M. L. Meadors, was appointed to study the problem in its various aspects and to make specific recommendations. As a result of a report by this committee, Council is recommending that the question of a Basic Science Law be considered by the House of Delegates. The Special Committee will present their report today for your consideration.

Council considered a bill, introduced into the General Assembly by Representative Jackson of Sumter, which would create an overall three man licensing board for practitioners of the healing arts. It was believed that this bill would not achieve the ends sought and Dr. Baker was requested to consult with Mr. Jackson concerning the rewriting of the bill.

Due to the current adverse publicity and the avowed intent of the Truman Administration to promote a Government Health Program, Council considered the advisability of securing help from a professional public relations firm as a measure to combat this program in South Carolina. Mr. Caldwell Withers, public relations executive of Columbia, was requested to submit a proposal for a general public relations program. After hearing this proposal, Council referred the matter to the Public Relations Committee consisting of Dr. O. B. Chamberlain, Chairman, Dr. R. F. Baker, and Dr. N. B. Heyward. The Committee ad-

vised Council that it thought the best interests of the Association would be served by amplifying the work done by its own public relations officers rather than securing outside aid. Council accepted this recommendation and provided extra help for this work.

When Council was informed of the action of the House of Delegates of the American Medical Association in levying an assessment of \$25.00 on all members of the A. M. A., Council approved the assessment and advised officers of the County Societies to assist in every way possible in collecting this assessment.

Council received a communication from the President of the Palmetto Medical, Dental and Pharmaceutical Association, asking for one representative from that organization on the Hospital Advisory Committee to the State Board of Health. Council discussed this fully and recommends to the House of Delegates that such an appointment be made in the person of Dr. T. C. McFall, Charleston, S. C.

The Womans' Auxiliary to the Association reported its activities for the past year to Council yesterday, through Mrs. P. M. Temples, president. The report indicated much fine work has been accomplished. The Student Nurses' Loan Fund is proving valuable in the nursing program. Council commends the Auxiliary for its untiring efforts, help and cooperation.

Your Council was asked to consider the election of the members of the Executive Committee of the State Board in the light of a By-Law passed by the House of Delegates two years ago, which states that "in case of an interim appointment in a committee, board of council such appointee shall be ineligible to succeed himself or herself in the South Carolina Medical Association."

Your Council discussed this question at length. Council had no criticism to make of the work of our present Executive Committee and commends its members for its fine efforts. It realized, however, that it would be wise to allow this House of Delegates the privilege of electing some new members to the Executive Committee if it so desires, but it does not think this should be done at the expense of those who have most recently come to serve on the Executive Committee, the interim appointees.

Therefore, your Council would make the following recommendations:

(1) That the action taken by this House of Delegates in 1947 relative to interim appointees, as it concerns itself with the Executive Committee, be rescinded.

(2) That a slate of twelve (12) names be presented to this House of Delegates. The names of the present seven members of the Executive Committee and the names of five (5) other members of The Association, the latter five to be presented by a special committee appointed by the President of the Association; that each delegate be instructed to vote for seven (7) of the twelve (12), and those seven (7) receiving the highest number of votes be declared elected and their names be recommended to the Governor for appointment to The Executive Committee of the State Board of Health.

Your Council received the following communication from The Sumter County Medical Society:

Council of the South Carolina Medical Association
Dear Sirs:

The physicians of the State of South Carolina are vitally interested in the existing statutes on the statute books in the State of South Carolina and any new laws which are proposed which can in any way affect the health of the people of the State of South Carolina. We have been acutely conscious of the legislation which was passed in 1942 allowing naturopaths to practice gynecology and obstetrics, minor surgery and use of biologicals which we feel they are not properly trained to practice.

Efforts were made during the last legislative session and are being made during the present session to inact some form of legislation which would limit the activity of this group. These efforts failed miserably in 1948 and the possibility of the inactment of such favorable legislation during the present session seem to be very poor.

Members of the Sumter County Medical Society have been keenly interested in seeing proper legislation passed curtailing practice of naturopaths. On March 23, 1949, Mr. Henry Jackson, representative from Sumter County together with other representatives from the State, introduced an act to repeal the clause of the act of 1942 which allowed naturopaths to practice gynecology and obstetrics, minor surgery and use of biologicals. This bill was approved by the council of the South Carolina Medical Association. Certain members of the council, and Mr. Meadors, were notified by Mr. Jackson on March 23, 1949 and were told the disposition of the bill and what committee it was sent to, together with the names of this committee. Apparently no action was taken by Mr. Meadors to inform various members of the House of Representatives concerning this bill and it stayed tied up in sub-committee. Six weeks after its introduction on May 4, 1949, Mr. Jackson desiring to get the bill out of sub-committee for debate in the House, moved that the bill be brought out for debate. He was defeated in this act because the members of the legislative body were not properly informed. During this six weeks period no official representative of the South Carolina Medical Association contacted Mr. Jackson to inquire concerning the progress of the bill. On further investigation it was found that there had been no official representative of the medical profession in our State capitol in direct personal contact with the members of our assembly here in the present session except on rare occasions. The important details of direct personal contact with the individual members of the legislator by a legal representative of the South Carolina Medical Association has apparently been grossly neglected.

Be it resolved that:—

1. Our legal council spend a large part of his time during the session of the assembly in Columbia, S. C. in order that he may both be present at the legislative session and be in a position to personally know and inform the members of the general assembly.

2. That the legal council of the South Carolina Medical Association be a person experienced as a lobbyist and possessing other such qualifications which are necessary to qualify him as a legal counselor that are so vital in keeping the members of the general assembly and medical profession properly informed.

Sumter County Medical Association
by J. E. Bell, Chairman

In 1944, our Association embarked upon an enlarged program of public relations and your Council was instructed to set up the necessary machinery, to secure a director, and to supervise the work of this department. Your Council carried out the instructions and secured the services of Mr. M. L. Meadors. Your Council has supervised his work and has had ample opportunity to observe his activities and to note the results of his efforts throughout the State. The report which Mr. Meadors presented to Council yesterday of his past year's work was ample testimony to the time and energy which he has devoted to his task.

Your Council, therefore, at its annual meeting, yesterday commended Mr. Meadors for his efforts and extended to him a vote of confidence.

The Councilors have been unusually active and diligent in their respective districts attempting to keep their Societies abreast of the various pending legisla-

tion of national and local interest. They have aided in every way possible in carrying out the functions of Council.

Mr. President, I recommend you, sir, that the resolutions be taken up separately, if that is your wish.

Respectfully submitted,
O. B. Mayer, Chairman

The Chair: I will request the Chairman of Council to stay at the microphone and take up each resolution separately.

Dr. Mayer: (Reading 1st resolution)

"Council considered the question of attempting to secure special State Highway automobile licenses with the letters "M.D." appearing thereon. It was decided that this matter be referred to the House of Delegates."

(Motion is made by Dr. Weston, Sr., seconded by Dr. Sanders)

Dr. Mayer: Council took no action on this, certain persons requested that doctors have their license tag designated with "M.D."

(The question was asked, "What does this motion, that we have passed, mean?")

Dr. Mayer: It means the Association will attempt to get these licenses with "M.D." put on them.

Dr. Brockman: A few years ago,—I might be responsible for that, there were several doctors in Greenville down at the airbase and they had a New York license on their cars with nothing but "M.D. New York." I said that is the best looking thing I ever saw. I immediately got a photograph of that and sent it to Dr. Preece, so that is the way it started.

The resolution was adopted.

(2nd Resolution of Council read by Dr. Mayer, Chairman):

"A communication received from the Women's Auxiliary relative to proposing a bill making diphtheria immunization compulsory for all children before entering school, was received and discussed. This matter is referred to the House of Delegates for consideration."

The Chair: What is the pleasure of the House of Delegates on that?

Dr. Weston: I think that is a very wise recommendation, that these women have made and I hope it will be adopted, sir, and I so move.

(Motion seconded by Dr. J. I. Waring)

Dr. Mayer: The women did not feel that they should push this legislation unless they received the sanction of the Medical Association.

The Chair: We must decide whether we will give our sanction towards the pushing of that proposed legislation.

(Some doctor made a motion that tetanus be added to that.

(Dr. J. Adams Hayne moved that typhoid be added to that.

(Dr. Frank Lee stated, "It is rather late, the age of six years is a little late.

(Dr. J. A. Hayne: He is exactly right, if you used toxoid you shouldn't use it after three or five. You must use toxin-antitoxin if the child is six years.

(Dr. Robert Wilson: We all agree this is a matter that should receive our recommendation, but as to its practicality of enforcement, I don't know. I should think we should hear from and refer the matter to the Board of Health and hear from it before we take any action on it.

(Dr. George Johnson: A few years ago a certain resolution was submitted to the State Board of Health, at that time they frowned upon it. North Carolina has a law requiring all children under one year must be

immunized against diphtheria and whooping cough. We know that passing the law will not bring about the cessation of these two diseases but it helps to publicize the fact.

The Chair: Dr. Wallace and Dr. Waring of the State Board of Health Committee have endorsed it.

(Someone from the floor stated "The doctor is right, it should be under one year."

Dr. Weston, Sr.: I move, Mr. President, then, that the recommendation of the ladies be approved and toxoid given to those who have not been immunized.

The Chair: Dr. Waring, that was the motion you wanted to second?

(Dr. Waring seconded the motion)

Dr. J. Dechard Guess: I wish to present a substitute motion which I think will get us further along with this than the motion before the house,—it is in line with certain suggestions that have been made. The motion is this:

That we approve the intent of the ladies in principle and that we refer it to a committee, to be appointed by Council, which in turn will request a committee to be appointed from the State Board of Health, to form a joint committee to work out the details of this intention.

(This motion was seconded by Dr. J. A. Haynes)

The Chair: Is there any discussion?

(Dr. R. M. Hope: I regret I cannot support a motion like that, it places in addition to all the unusual committees that we have now another committee and that committee must call on a committee of the State Board of Health,—it seems all the ladies are asking is the backing of the House of Delegates with the principle they have started and the details should certainly be left to the ladies to work out. I see no need in appointing another committee.

(Dr. Lee: It is very difficult to back the ladies in something you don't approve of yourself.

(Dr. Everett Poole: I think what we should realize is the ladies are asking our moral support and are not asking us to formulate for them the exact details or mode of diphtheria immunization. They are making an effort to get our moral support to getting the principle of diphtheria immunization made into the law for school admission. The practicality of enforcement of such a law, it would be a job to enforce such a law at the age of one, two or three years, but inasmuch as school admission is a very important legal change in his status, the admission of a child to school permits checking that child's physical status and has made it possible for this section of this country to legalize and enforce certain medical immunization methods which otherwise would not be practicable or possible. It is our moral support these ladies want and we should give the ladies all the support we can. I believe they are probably asking for our approval of their effort to make diphtheria immunization a pre-school requirement without a statement at this time as to when it should be done.

The Chair: All those in favor of Dr. Guess' motion, signify by saying "aye" (A number of "ayes" were heard.)

All those opposed, signify by saying "no." (A number of "noes" were heard.)

All those in favor of Dr. Guess' motion signify by rising. (The Secretary counted thirty-five (35).)

All opposed, signify by standing. (The Secretary counted thirty (30).)

The Chair: The "ayes" have it, it is so ordered.

(3rd Resolution of Council read by Dr. Mayer, Chairman):

"Council received a communication from the President of the Palmetto Medical Dental and Pharmaceutical Association, asking for one representative from that organization on the Hospital Advisory Committee to the State Board of Health. Council discussed this fully and recommends to the House of Delegates that such an appointment be made in the person of Dr. T. C. McFall, Charleston, S. C."

(A motion to accept this recommendation was made by Dr. D. O. Winter, and was seconded by Dr. Robert Wilson, Jr.)

(Dr. J. A. Hayne, recognized: I move we lay this recommendation on the table. I see no reason whatsoever to put a negro on this Board in this State. We have gotten along very well so far without them and we will get along better in the future.)

The Chair: The motion has been made to put this resolution on the table, is there any second?

(There was no second)

Is there any discussion? (There was none.)

All in favor of the motion to adopt the recommendation made by your Council signify by saying "aye."

(There was apparently a unanimous vote in favor of the motion, but the Chair called for those opposed and Dr. Hayne was the only delegate to vote "no.")

The "ayes" have it and it is so ordered.

(4th Resolution of Council read by Dr. Mayer, Chairman):

"Your Council was asked to consider the election of the members of the Executive Committee of the State Board in the light of a By-Law passed by the House of Delegates two years ago, which states that "in case of an interim appointment in a committee, a board of council such appointee shall be ineligible to succeed himself or herself in the South Carolina Medical Association."

"Your Council discussed this question at length. Council had no criticism to make of the work of our present Executive Committee and commends its members for its fine efforts. It realized, however, that it would be wise to allow this House of Delegates the privilege of electing some new members to the Executive Committee if it so desires, but it does not think this should be done at the expense of those who have most recently come to serve on the Executive Committee, the interim appointees.

"Therefore, your Council would make the following recommendations:

"(1) That the action taken by this House of Delegates in 1947 relative to interim appointees, as it concerns itself with the Executive Committee, be rescinded,

"(2) That a slate of twelve (12) names be presented to this House of Delegates. The names of the present seven members of the Executive Committee and the names of five (5) other members of The Association, the later five to be presented by a special committee appointed by the President of the Association; that each delegate be instructed to vote for seven (7) of the twelve (12), and those seven (7) receiving the highest number of votes be declared elected and their names be recommended to the Governor for appointment to The Executive Committee of the State Board of Health."

The Chair: I am going to divide the two resolutions, rescind the action of the House of Delegates two years ago, which has to do with the re-election of any appointee made for an interim appointment, made between the meetings of the House of Delegates.

Dr. Mayer: Only as it concerns the Executive Committee of the State Board of Health.

The Chair: Do I hear a motion to rescind that?

(Dr. Guess: I rise to a point of information, I ask, and I direct these remarks to the Secretary. Was that change which we made in 1947 a change in the By-Laws?

(Dr. Price: It was a change in the By-Laws and the By-Laws can be changed in any meeting of the House of Delegates by a two-thirds vote.)

Motion:—By Dr. J. D. Guess: I move that that particular By-Law be amended to eliminate "interim appointments to the Executive Committee of the State Board of Health."

(This motion was seconded by Dr. N. B. Heyward.)

(Dr. Robt. Wilson, Jr.: I would like to ask for information.

Who made the interim appointments, did the Executive Committee of the State Board of Health make them or did Council make them and were they later appointed by the Governor; and how many of the present State Board of Health are so affected?

The Chair: There are three members of the State Board of Health affected. Dr. Wynman is here, will he answer that please?

Dr. Wyman: The three members are appointed by the executive committee in accordance with the statutes of the State. They are Dr. Durham, our President, Joe Waring, of Charleston and Keitt H. Smith of Greenville.

The Chair: Is there any further discussion?

(Dr. A. R. Johnson: I would like to ask if the motion made was the full intent of Dr. Mayer's resolution?

The Chair and Dr. Mayer: Yes, that covered it.

The Chair: Is there any further discussion? If not those in favor of the motion signify by saying "aye." Opposed "no." The "Ayes" have it and it is so ordered.

Now, the second part of the resolution, that twelve names be presented, and each delegate vote for seven of the twelve.

(Dr. Mayer: In other words, that means that automatically the seven names of the present committee of the State Board of Health remain plus five additional names, making the twelve, which you will vote on.

Motion: By Dr. R. M. Hope: I move the adoption of that resolution. (This was seconded by Dr. A. R. Johnson.)

(Dr. Robert Wilson, Jr.: There is a question I would like to bring up. I think this is the most important election and most important committee appointed or elected by the State Association. I think the membership had best be determined by a nominating committee, as the resolution calls for.

(Question from the floor): I would like to know if the seven men have to be apportioned to the seven districts. I offer the amendment that seven additional, rather than five additional be put up. I would like that question asked.

The Chair: Do the seven members of the Executive Committee of the State Board of Health have to be apportioned to the seven Districts, Dr. Wyman?

Dr. Wyman: The law says seven men shall be nominated to the Governor, it says nothing about territorial distribution.

The Chair: It has been a custom to have one appointment from each section of the State, merely a custom.

Motion: By Dr. Robert Wilson, Jr.: I think, if they are distributed through the State we should have seven additional names.

I amend the motion to strike the word twelve and put fourteen.

Dr. Price: (Recognized by The Chair) This was brought up in Council yesterday and I am not voicing

my own opinion, I am simply stating the reason for five. There was a bare possibility you might have seven new men coming in on the Executive Committee, which might not work well. Therefore, they felt if you were assured of two of the seven going back on it, it might lend continuity.

First Motion: Dr. R. M. Hope: I made the original motion and, with due respect to Dr. Wilson's comments, I prefer not to accept the amendment.

The Chair: Is there any further discussion?

The resolution was adopted.

(5th Resolution of Council read by Dr. Mayer, Chairman):

This is in regards to the Sumter County Medical Association's letter regarding Mr. M. L. Meadors.

Council took this action: (Reading)

"Your Council, Therefore, at its annual meeting, yesterday commended Mr. Meadors for his efforts and extended to him a vote of confidence."

Dr. Mayer: We felt the House of Delegates would wish to make its own feeling known.

Motion: By Dr. Everett Poole: I move you, sir, the House of Delegates goes on record as commending Mr. Meadors in his efforts and expressing our appreciation and commending with sincerity his efforts for this Association.

(This motion was seconded by Dr. Jack Parker)

(Dr. W. Thomas Broekman—Recognized: I would like to say a word.

I remember very clearly, as all of us do, when we started this new plan in having an Executive Director and Public Relations man, and I don't know of any one who could have filled that place quite so well as Jack Meadors. He is an attorney, he has fitted in with us fine. I have caught a little of this spirit that this letter mentions here. A lot of that probably is due to us. We haven't helped him a lot. I have had him call me, wire me, "Come to Columbia!" And he would catch me on a short day, when I couldn't go. I realize that is a big job for Jack to have to meet and know all these new men, as they come in each year. And I was asking a few of our new men if they knew Mr. Meadors, I was sort of cheeking up on them, and they said, "I think I have met him."

Well, Jack may not be the best lobbyist in the country, but he is a good man for us. I am glad we are going to back him up here, he needs it. This might make him a better lobbyist.

(Dr. N. B. Heyward (Recognized by The Chair): I am a member of the Legislative Committee of this Association. The Chairman of it, Dr. Chamberlain, is in Charleston. If anything happens in Columbia, I am there, and it takes Barney Heyward to go and fight it. It is a dirty job.

I have been concerned chiefly with the fighting of these "Naturopaths." I have fought every year and gotten actually nowhere. Any effort to do something is blocked. And people demand that you do something with the Naturopaths. Council appointed a committee and it was decided to sponsor a Basic Science Law, and they thought that was going to cover it. A proposed bill was drafted and Council told the committee to confer with the State Board of Medical Examiners, they were called in, and the Committee reported back to Council and Council decided she should take no action but leave it to the House of Delegates at this meeting,—so much for the Basic Science Law.

Council decided to try to do something about repealing the provisions in the present law which were added during the War years, slipped in on them, to let the Naturopaths practice obstetrics, and gynecology and prescribe biologicals. Let me tell you, the Naturopaths took advantage of it, they are really going to town. We figured the Basic Science Law wouldn't help that. They instructed Jack Meadors to introduce that bill to get that out. He did it, and it went to Committee and was referred to a sub-committee. I

went personally, every week, to see how that bill was doing, it was still in committee. I finally went to the Chairman of that Committee and head of that sub-committee, to which the Naturopathy Law was referred. I got hold of that Chairman and I really got a talking to, I got a dressing down, he wanted to know what the damn doctors were trying to do, get a monopoly? Were they trying to put them (the Naturopaths) out of business? He said, "We are not about to bring it out of Committee. If you have bad Naturopaths, you have laws, put them in Court and put them out of business. I don't want to be personal but you have some bad doctors." That is what I got from him. We got nowhere, we have no idea of bringing it out of committee,—if the house brings it out, the senate will block it. I tell you gentlemen, I have been fighting this year, many years,—I am discouraged.

Jack Meadors' efforts in that direction were backed up, certainly by me, certainly by some others, and we got exactly nowhere with it. That is the truth of the matter.

The Chair: Is there any further discussion? If not we will call for a vote on the motion.

(The question was put and the motion was carried unanimously, there being not a single "no" voted.)

The Chair: I wish to appoint the following on the Resolutions Committee:

James Young, Chairman,
Tom Broekman
Buck Pressly

Also, I appoint the following as the Nominating Committee for the State Board of Health:

George Truhack, Chairman,
Wyman King
Harold Gilmore
Charles Wyatt
John Van de Erve
(Adjourned for Luncheon)

HOUSE OF DELEGATES

2:30 P. M., May 17th.

Presiding—Dr. R. B. Durham, President.

The Chair: The next is the report by the Chairman of the Executive Committee of the State Board of Health, Dr. W. R. Wallace.

REPORT OF THE EXECUTIVE COMMITTEE OF THE STATE BOARD OF HEALTH

Mr. President and Members of the House of Delegates:

This year instead of reading a formal report we wish to present a number of slides with brief comments. These will show some very familiar scenes and facts to most of you but there are probably a number of you who have not had an opportunity to see each and every one of the projects of your Board of Health. In this way we hope to give an overall review of the organization and activities of the past several years.

The Board of Health remains with a few changes as set up by the act of 1878 which constitutes the South Carolina Medical Association as the Board of Health to operate through an executive committee.

In addition to the seven members recommended by this Association for appointment by the Governor and the two ex-officio members, there has been added a dentist, and a pharmacist. This year under the sponsorship of the South Carolina Nurses Association, a graduate nurse will probably be added. She will be recommended, appointed and serve similar to those of the other associations.

The State Health Officer—Secretary is recommended by the Executive Committee for appointment by the Governor.

In order to expedite the affairs of the Department of Health and to prevent overlapping, sixteen Divisions have been set up.

Division of Administration—The Division of Administration has a supervisory relation to the other divisions and is under the immediate supervision of the State Health Officer. There are three important Sections in this Division. The Personnel Section keeps a complete file for each employee which contains record of training and experience, annual and sick leave record, retirement and group insurance records. In filling vacancies the applicant must be taken from eligible Merit System lists.

The Tabulating Section indexes all birth and death certificates with important statistical information. Various other statistics are arranged and tabulated.

The Bureau of Information Service maintains a library of motion picture and film strips which are available for schools, civic organizations, and groups interested in health programs.

Division of Local Health Services—This is the central administration unit under which all county health departments function. The great problem in this division is keeping a sufficiently large personnel trained to fill all vacancies. The problem is very much increased by the fact that we operate upon a lower salary scale than our adjoining states, the Veterans Administration, and other agencies.

Division of Sanitary Engineering—This division is concerned with prevention of transmission of diseases by proper supervision of water supply, sewerage disposal, waste disposal, slaughter houses, freezer lockers, canneries, etc. Advice and plans are furnished or approval given for construction of water plants and sewerage plants.

Division of Preventable Diseases—By analysis of reports from physicians, investigations of epidemic and threatened epidemic, immunizations and programs for endemic diseases, this division performs a most vital function.

Division of Maternal and Child Health—This division was established for the purpose of reducing maternal and infant mortality and for promoting better living standards in South Carolina. The marked lowering of mortality and morbidity rates has amply justified this undertaking.

Division of Cripple Children—This division provides clinic services, hospital care, foster homes, convalescent home care and braces and appliances for cripple children of this state. It also carries on a rheumatic fever program which supplies medical, hospital, and convalescent care for rheumatic fever cases. More than 8000 children in South Carolina are listed as orthopedic cases. Hospitalization is provided in Spartanburg, Greenville, Columbia, Florence and Charleston. The South Carolina Convalescent Home in Florence, where physical and occupational therapy is provided, plays an important part in the work of this division. Summer camps are operated by this division each year at Poinsett State Park in Sumter County. 300 handicapped children are benefitted by these camps each year.

Division of Dental Health—The activities of this division is directed primarily toward the prevention and control of dental diseases among school children. In cooperation with the County Health Department and local school authorities, clinics are held for discovering caries and other defects. Also prenatal and postnatal patients are given the benefit of this service in cooperation with the M. C. H. Division. Right at this time considerable work is being done to show the value of fluoride treatment to prevent decay.

Division of Tuberculosis Control—The activities of the State Board of Health are administered by the Division of Tuberculosis Control and the South Carolina Sanatorium. The former is concerned with case findings and checking contact and followup of discharged patients. In this work fluoroscopic and x-ray

examinations in health departments, mobile x-ray units, x-ray facilities in general hospitals and the out-patient clinic at the Sanatorium are used. The South Carolina Sanatorium located eight miles from Columbia is doing a splendid work in the treatment of tuberculosis. This splendid hospital is equipped to utilize all modern methods of treatment such as collapse therapy, including all forms of major and minor chest surgery. The shortage of personnel is a problem here also. At present there are 328 beds for whites and 222 for colored patients. With money appropriated by legislature and funds from The Hospital Construction Program, 100 beds are being added. The colored department will be situated adjacent to the present hospital building and will make the operating and culinary facilities more efficient to the colored patients.

Division of Venereal Disease Control—The object of this division is locating, diagnosing, and treating infectious cases of venereal disease, also trying to locate for examination contacts. This department operates through the county health department and the South Carolina Public Health Hospital (Rapid Treatment Center). Only the early cases are treated in Florence. The cases of long standing and of little danger to the public are allowed to assume the responsibility of treatment themselves. Only indigents are taken. Granuloma inguinale is treated at the South Carolina Public Health Hospital.

Division of Cancer Control—This division administers the act of legislature passed in 1939. The act provides for the diagnosis and treatment of indigent persons suffering from cancer at the expense of the state. There are nine cancer clinics set up in the different parts of the state to which cancer cases may be sent. The physicians who conduct these clinics gives their service free of charge and the hospitals are reimbursed for actual cost of caring for these patients. Any doctor in South Carolina who has a patient who he thinks has a cancer and does not have money to pay for proper examinations and treatment may send him to one of these clinics. In 1947 legislature passed a bill establishing a statewide clinic under the authority of the Medical College which can take far advanced cases for the purpose of nerve destruction to alleviate pain, removal of certain glands such as the testes and ovaries in appropriate case and for research.

Division of Industrial Health—This division is concerned with the health of the industrial employee and to make their working environment as free as possible of occupational hazards. Information is furnished on toxic materials and harmful conditions encountered in industry. Another service offered is examination of urine and blood for toxic substances, inspection of lighting and ventilation, investigating humidity, gas, fumes, and foreign materials that might be inhaled.

The Hospital Construction Division—This division was set up in 1947 to administer the provisions of the Hill-Burton Act. There has been a great deal of work done in two years. A few hospitals have been completed, many are under construction and a great many plans are in the processing stage.

The Hospital Center at the Medical College is already to begin construction as soon as a few minor details are worked out.

Many health centers are being completed each month. The State Hospital and the South Carolina Sanatorium are beneficiaries under this program and will have much needed additions.

Division of Vital Statistics—Since 1915 certificates of births and deaths have been required to be filed with this division. There have been many improvements made through the years and many more are needed. It is still difficult to get full and accurate data.

Beside the immense work of collecting and filing these certificates, there are many corrections to be made because of failure to report on births, adoptions, legitimations, and furnishing copies to applicants, attorneys, courts and the children bureau.

Division of Laboratories—Probably more physicians come indirectly in contact with this division than any other. Nearly every physician in the state makes use of the laboratory facilities in one way or another. A tremendous number of blood tests, smears, sputum examinations, malarial slides are examined each day. Antirabies treatment are furnished and animals suspected of rabies are examined. We feel that all this work is done in an efficient and reliable manner.

Division of Finance—This division is responsible for receiving and distributing all monies from all sources, for budgeting and accounting all appropriations made available for the State Board of Health, whether State or Federal. This includes all funds for operating all of the institutions operated by the Board except the South Carolina Sanatorium which operates upon its own budget.

In conclusion let me express our deep appreciation to the various advisory committees that have given such valuable and helpful service. To the various clinicians and the orthopedic surgeons and others who have given unstintingly of their time and talent.

Also let me say that now as never before every doctor should support all public health measures. With socialized medicine in the offing we must at this time furnish efficient and liberal services to people everywhere both in the curative and preventative field of medical care. This is our best method of defense.

Dr. W. R. Wallace, Chairman
Executive Committee of
The State Board of Health

The Chair: Report of Delegate to A. M. A.

I am informed Dr. Hugh Smith is ill and he has asked Dr. William Weston, Sr., to give us a short report on the activities.

Dr. William Weston, Sr.:

Gentlemen of the South Carolina Medical Association, in the first place I need not go into the details of the acts of the House of Delegates in the last two sessions, because the minutes of those two meetings have been published in full in the Journal of the American Medical Association. But I wish to emphasize one matter, that is this assessment that has been made by the House of Delegates of the AMA.

Now, what was the reason for that? It was found that this Social Security Administration has been sending its representatives in quite large numbers to almost every meeting that was held by laymen throughout the United States to impress upon them the importance of the adoption of the socialization of medicine.

In view of that fact and in spite of the fact that we had abundance of information to disprove the statements made by Mr. Oscar Ewing, who had been abundantly discredited by commentators and other sources of information throughout the United States,—it is useless for me to tell you that he has made many statements that are absolutely false and without any foundation in fact. Now, in order that the American Medical Association, in your behalf and in my behalf should present the facts, they went ahead and employed coordinators, in order that all the information which we have might be presented to the authorities in Washington.

This was done, but it was found that the United States Government had infinitely more money to spend in behalf of the claims of this Social Security Administration than we had in the American Medical Association. So, they made this very modest recommendation and assessment. We paid that, most of us most willingly. Many paid much more than their assessment because we all felt, and have felt in the

House of Delegates in the Association, for many years that the regimentation of the medical profession would not only be a mortification and a destruction of the progress of the medical profession but that it would not be in the interest of the people of this country.

Now, who was it wanted this socialized medicine? It was the Communists, the advanced Socialists, the labor leaders, not the personnel of the Unions, because they realized perfectly well, when the facts were presented, that if the requisite amount of money was deducted from their payrolls they would not have the take-home pay that they would wish to have. Consequently, it was not the personnel.

But now, may I read from this little pamphlet, that Dr. Price has spoken to you about and that I hope will be in the hands of every member of the South Carolina Medical Association. Who is against this thing? Not only the Medical Profession, but 5,000,000 women in the General Federations of Womens Clubs, The American Legion, The American Farm Bureau Federation, the American Bar Association, the National Association of Small Business Men, The United States Chamber of Commerce, The National Federation of Business, Inc., The American Medical Association, the American Hospital Association, the National D. A. R., the Women's Patriotic Conference on National Defense, and many others.

Every medical man in the United States should stand by the American Medical Association in this fight that they are making for us. I sat in the House of Delegates for years. I have known the agony through which they have gone in defense of this great principle. They know that the socialization of medicine has been an utter failure in every country in which it has been tried. We see England today, with a staggering cost, a cost that could not be sustained except by the help of the Treasury of the United States.

If you will read this little Pamphlet, which these men, who have been employed by the House of Delegates, have gotten up for the coordination of all of these facts, a few of which I have announced to you, I am satisfied that you, if it is necessary, would spend the last dollar that you have for the salvation of the human beings in the United States and for the preservation of our profession as we know it. Thank you.

(Applause)

The Chair: Thank you very much, Dr. Weston.

I am going to suggest to the Secretary of the Association that we send Dr. Hugh Smith a wire expressing our regrets that he is ill.

Report of State Board of Medical Examiners—*Dr. N. B. Heyward.*

Report of State Board of Medical Examiners for 1948
Physicians licensed by written examinations.....57
Physicians licensed by reciprocity.....36

Total licensed93
Licenses reinstated 1
Licenses certified for reciprocity to other States.....40

Gain in licensed physicians in S. C.54
Duplicate licenses issued 5

Respectfully submitted,
N. B. Heyward, M. D., Sec.

Report of Cancer Control Commission—*Dr. J. R. Young, Chairman.*

Dr. Peoples (Recognized)

We have the report mimeographed, so I won't make a speech, but there are two things not included in the report, one is that we should be very proud of the fact that South Carolina has the lowest true mortality cancer rate in the United States. When this death rate was standardized we still remain third lowest.

The second thing I would like to correct an im-

pression, not so much an impression but a piece of propaganda, that the greatest percentage of people attending our cancer clinics die very soon after attendance. We have made a nine years survey and during that period 70% of the patients attending the clinic are still living and apparently cured, or probably cured.

Report of Scientific Committee—Dr. D. F. Adcock, Chairman

Dr. Adcock: Mr. President, ladies and gentlemen, my committee would like to express its appreciation to the members of this Association for the excellent co-operation we have had in getting this program set up. Particularly do we want to thank the office at Florence and Mr. Powell, who volunteered his services to run our lantern here during the entire meeting.

When we first started planning our program it appeared that very few were interested in getting on the program, but, as time wore on and the meeting time approached, this situation reversed itself to the point of embarrassment to the Committee. We hope some of these papers, or most of them will be offered the next program committee in time for them to begin setting up the framework for next years' program.

I must admit we had a hopeless feeling when we came to Myrtle Beach for the Convention, because we have so many outside influences to compete with our scientific program. The Committee hopes you find the program as set-up both enjoyable and profitable and you will go home to practice a better brand of medicine.

The Chair: The next will be the Report of Committee on Legislation and Public Policy—*Dr. George D. Johnson, Chairman.*

REPORT OF THE COMMITTEE ON LEGISLATION AND PUBLIC POLICY

Very little of interest to physicians has been introduced in the Legislature this year. One Bill introduced by the Naturopaths themselves, originally as H.1248 is a step in the right direction. It would more clearly define and extend the authority of the Board of Naturopathic Examiners to revoke licenses of their practitioners. The original Bill contained one objectionable provision and for that reason was shelved by the Committee on Military and Public Affairs to which it was referred. The Committee substituted its own Bill (H.1387) which now has passed the House and will probably become law before the end of the session.

There has been no report from the Committee on Military and Public Affairs and no action on Bill (H.139), by Mr. Davis, to repeal all of the statutes on the practice of Naturopathy. There probably will be none.

The Bill by Senator Wallace, and others, (S.123) is having rough sledding. It proposes to appropriate 4 million dollars to be used in the construction of hospitals and medical centers. The Bill received a divided report from the Senate Finance Committee and its passage is doubtful.

The Bill originally introduced by Mr. Jackson of Sumter to create a State Licensing Board has been pigeon-holed and will probably not reach the floor or the House.

Mr. Jackson also introduced another Bill (H.1440) to repeal the section of the Code which authorizes the practice of minor surgery, obstetrics, etc., by the Naturopaths. This was the Bill which Council felt should receive the support of the physicians. Even if it is favorably reported by the sub-committee to which it has been referred, and the Committee on Military and Public Affairs, it hardly stands a chance of passing this year.

As far as Public Policy is concerned, the practice of medicine as we know it is on trial for its existence. Our best approach to the high cost of medical care

both by hospitals and by physicians' charges is through voluntary hospital and health insurance. It is the duty of every physician to urge his patients who do not have hospital insurance, to buy Blue Cross and, if the House of Delegates approves the plan—Blue Shield. This combination offers more for the money than any other insurance. This combination has the backing of the Medical Association and it is up to the doctors to help sell it to their patients. Only by selling more and better insurance to our patients can we avoid medical care by the Government.

The Chair: The next Committee Report is one we all think is most important and I want to say this for the Chairman and the entire Committee, they worked hard throughout this year. They have had numerous meetings and Council thinks they have an excellent plan to offer,—so it gives me pleasure now to introduce the next speaker, Dr. J. D. Guess, the Chairman of the Committee on Medical Service, Dr. Guess.

Dr. Guess: I would like, before reading my report, to outline briefly what we have done.

This report is the culmination of four years of work. There was first a committee appointed by the president of the House of Delegates to look into this matter and to make a report to you, and that committee studied Blue Shield plans, as they were in operation in various parts of the United States and particularly as they relate to the enabling acts in the various states, because we felt that the enabling acts was the first step in providing for these plans.

After two years we succeeded in passing through the Legislature a rather simple Act but one the committee felt met the needs of South Carolina. There are just two features of that Act I would like to stress in the preliminary remarks. One, under the Enabling Act of South Carolina any group of doctors can establish in a limited territory in the State a pre-paid medical care group, but any group that does set-up such a plan has to have, as cooperative physicians, 50% of the doctors licensed to practice under our Medical Practice Act. So that is a little hedging there that protects us. The second feature of the Enabling Act that we think is wise is that not only do we have to have 50% of the cooperating doctors but only licensed physicians, under our Enabling Act can cooperate, that is, licensed physicians under our Medical Practice Act.

Last year at the House of Delegates this Committee of the House of Delegates threw this whole problem into your laps and you threw it into the laps of Council. Our Committee felt that we had gone as far as we could with the authority that we had then. As you heard this morning, the Council took up this matter at their first special meeting and appointed a Committee of Council. Somewhat to my distress, I, not being a member of Council, they made me a Chairman of this Committee and so this New Committee started to work on this problem and it is as a result of their study and conferences, with the help of the Council, that we have worked out the plan that we expect to present to you this afternoon, and this committee, which is really a committee of Council, is bringing this report to you at the request of Council,—and in this particular instance I stand before you as a representative of Council, but your Council has verified and approved every single feature of this plan, so that you might say, in the beginning, this plan has been approved by a considerable number of the Members of this Body, already.

Now, the plan that we are proposed to use is this: The territory of the plan will be the State of South Carolina; the owners of the plan will be the Delegates who sit in the House of Delegates, they are the Incorporators, they are similar to the stockholders in a corporation.

A Board of Directors will actually operate the plan, under a set of By-Laws, which you will either approve or disapprove this afternoon. Those By-Laws hedge the action of the Board of Directors just like the By-Laws of a corporation hedge the action of the Corporation Board of Directors. The By-Laws provide that this insurance coverage, it is actually that, will be offered to all people of the State, provided they are in groups and already exist or will have been in existence before they apply for the coverage but the group may be as small as two or as large as the biggest corporation group of employees. In the smaller groups all the members of the group will have to apply; in the larger groups 50% will have to apply. The subscribers, as they are called instead of policyholders, will be divided into two groups, so far as their coverage is concerned. There will be those who are called unlimited subscribers, whose family income in money or kind will not exceed \$3500.00 a year and to that group the cost of covered illnesses, as far as the doctors' fees are concerned, will be covered because the cooperating doctors will have agreed to accept the fees, as provided in the Plan's Fee Schedule, in remuneration for the covered illness.

In the other group of the subscribers, those of the family income of more than \$3500.00 a year, the subscribers will be termed limited subscribers, and they will not receive complete remuneration for the cost of their medical care, so far as "Covered illnesses" are concerned, but the doctors, their doctors, will arrange with them, just as you and I do now, what the fee will be and the Plan will send to the doctor the amount provided for in the "Fee Schedule" and he will collect the balance from his patients, just as you and I do now.

And as a family's circumstances alter from time to time, they may be in one group one time and in another group another time.

Now, those are the salient features of the plan.

With respect to the "Fee Schedule" let me say this, we have taken as a basis, and there was a large committee of doctors who considered this, the Fee Schedule of the North Carolina plan. The Fee Schedule of that plan is now in effect, it represents the second revision or the third schedule. It has been revised upward, as our economic situation has improved, and this new Fee Schedule has been the result of a recent revision that came out of the study of a tremendously large group of doctors in the State of North Carolina. We have made very few changes in those Fee Schedules as used. There are a few minor changes.

In our cases these fees represent perhaps on the average of about a 25% reduction in your minimum fees, not your average fees, not your big fees, but your minimum fees. There is not a single one of us in this room but who would be willing to give a 25% commission to any organization that would guarantee to collect a minimum fee for every case that we handle, so we think this Fee Schedule, when looked in that light, is a wise schedule.

There is one thing I would like to say with regard to the Board of Directors of this Committee, and the Council agreed with us. We felt that the consumer should be represented on the Board of Directors of our Plan. So, in the Plan I will present to you there is a provision for a Board of Directors of fifteen members. Eight of those members will be doctors and seven will be laymen. The laymen who have worked with us, as the tentative Board of Directors, have worked, are our friends. They stated, "We have the finest group of doctors in South Carolina, they are a marvelous group." And those laymen will be liaison

men in their communities to help us put this thing over and at the same time they will give us the benefit of their best judgment. Those are the main features of the Plan.

REPORT OF THE COMMITTEE ON MEDICAL SERVICE

Mr. President and Gentlemen of the Council,
South Carolina Medical Association:

The special committee, consisting of myself, Dr. Howard Stokes and Dr. W. Wynnan King, appointed by you to study further the question of organizing a voluntary, cooperative medical service, or Blue Shield, insurance plan under the provisions of an act passed by the General Assembly of South Carolina in 1948 and titled "An Act To Provide for the Chartering and Method of Organization and Operation of Non-Profit Corporations" etc., submits the following report and recommendations:

On May 11, 1948, a special committee on medical service, of which I was chairman, reported to the House of Delegates of the South Carolina Medical Association in part as follows:

"The committee recommends that the House of Delegates authorize and instruct the Council to proceed with the incorporation of a medical service plan for South Carolina, in accordance with the laws and regulations applicable, and that members of the Council be and compose the corporation." Presented along with the report and forming a part of it were certain documents, which were designed to serve as a basis and an outline for discussion and decision by Council when it came to consider actual plans and procedures in carrying out that recommendation of the Medical Service Committee. The House of Delegates adopted the report of the committee.

Your committee has carefully studied the report of that earlier committee and its recommendations and suggestions and it bases this report on that study of material which was the result of two years of careful study. It is the opinion of your committee that the Council has been given a mandate to proceed with the incorporation of a medical service plan for South Carolina. Therefore your committee recommends:

1. That Council instruct our attorney to apply for a charter of incorporation for a medical service corporation, to be known as the South Carolina Medical Service Plan, or by such other title as the Council may select.
2. That the members of Council be designated as the incorporators, but that the members of the House of Delegates of the South Carolina Medical Association make up the corporation and be designated as the members of the corporation.
3. That the incorporators (the Council) give thought to the personnel of a Board of Directors and be prepared to nominate at the first meeting of the corporation (The House of Delegates) a Board of Directors of 15 members as provided for in the By-Laws of the corporation (to be discussed later).
4. That Council discuss the following recommendations of your committee, and present them as they are or as Council alters them, to the House of Delegates at its next annual meeting or at a called meeting as Council shall decide:
 - a. That the Board of Directors be instructed to set up a combination service and cash indemnity plan, by which it is meant that there shall be two types of contracts offered: the service type which will provide benefits in

terms of physicians' services, and the cash indemnity type which will provide benefits in terms of money as set forth in a given "schedule of indemnities."

- b. That service contracts be offered only to persons with a combined family income not exceeding \$3,500.00 per year.
- c. That until more actuarial experience is acquired, coverage be limited to the following types of medical service; obstetrics in the home, in the doctor's office or clinic and in the hospital, and to surgery in the doctor's office, or clinic and in the hospital; and that no medical coverage be offered.
- d. That there shall be imposed a waiting period after date of the contract, of six months before the coverage becomes effective in the following types of surgery: Tonsillectomy, hemorrhoidectomies, and herniorrhaphies (except operations on strangulated hernias); and that a similar waiting period of 10 months be provided in coverage for obstetrics.
- e. That in all cases, the insurance shall be group coverage, and that it shall be offered to no group smaller than five, which group must already be established, and not having been formed for insurance purposes, and that for groups of less than 10, all members of the group must belong to the plan, and for groups of 10 and over, at least 75 percent of the members of the group must belong to the plan.
- f. That for cash indemnity contracts, there shall be made up a schedule of fees, that this schedule shall be made up by a committee from the House of Delegates (the corporation), and that it shall be approved by the House.
- g. That family contracts shall cover the spouse, unmarried children under 21 years of age and overage unmarried dependents.
- h. That the Board of Directors be instructed to make the necessary actuarial studies and to set the fees to be charged for the contracts to be offered.
- i. That benefits not include diagnostic X-ray studies, anesthesia, and other laboratory services already offered in contracts of the South Carolina Hospital Service Plan.
- j. That the South Carolina Medical Association appropriate \$10,000 from its treasury funds, as a non-interest bearing loan to the Medical Care Plan, the same to be repaid when accumulated reserves are such that it can be done safely and that the Board of Directors be authorized to solicit and receive gifts and loans from other sources.
- k. That the House of Delegates approve in principle the recommendation that the Medical Care Plan seek an arrangement with the South Carolina Hospital Service Plan whereby the latter will be the accounting and selling agent for the former.
- l. That Council approve the following By-Laws, as altered by it, as the governing regulations of the Medical Care Plan, and that it recommend their adoption by the Corporation (House of Delegates) at the meeting for the purpose of organization.

J. Deehard Guess, Chairman
Howard Stokes
W. Wyman King

Then, Mr. President, if it is in order for the Committee, and in order to get this matter before the

House, I have prepared several motions which I should like to present one by one and let the House take action on them?

The Chair: You have the floor.

Dr. Guess: (Reading) "For the Council, the Committee and the tentative Board of Directors, set up by Council: I. I move adoption of the plan which has been outlined by me, including as it does combination service and indemnity, with service (unlimited) subscribers restricted to persons or families with a yearly family income not exceeding \$3500 in cash or kind, coverage to be limited to surgery and obstetrics as indicated and the protection offered to be of the group type.

The Chair: Do I get a second? (The motion was seconded by Dr. Walsh).

Dr. Blake: How would it do to read all of the motions and let us pick out any one that we do not want?

Dr. Guess: If you stop any of this, you might as well stop it all.

The Chair: Is there any discussion? If not, I will give you the motion. (The motion was voted on and the "ayes" carried.)

It is so ordered.

Dr. Guess: (Reading):

II. I move further that the By-Laws as presented in summary be adopted.

(This motion was seconded by Dr. Pressly, there was no discussion, the vote was taken and the motion was passed unanimously.)

III. I move further that the tentative fee schedule prepared by the Committee be approved.

(This motion was seconded by Dr. D. O. Winter, a vote was taken and after the vote was taken the Chair asked if there was any discussion. (There was none) and the Chair said, "It is so ordered.")

IV. I move further that the following Board of Directors be elected:

To serve for one year, or until the next annual meeting of the corporation:

Dr. J. Deehard Guess
Dr. Wyman King
Dr. John Siegling
Mr. Jesse Anderson
Mr. M. L. Meadors

To serve for two years, or until the second annual meeting of the corporation:

Dr. J. Howard Stokes
Dr. C. R. F. Baker
Dr. W. T. Barron
Mr. Earl Britton
Mr. R. C. Edwards

To serve for three years, or until the third annual meeting of the corporation:

Dr. George D. Johnson
Dr. A. C. Bozard
Mr. George Wilds
Mr. W. W. Loran
Mr. J. D. Ashmore

(As Dr. Guess read out the names of the laymen named to serve on the Board of Directors, he made the following references to them:

Mr. Jesse Anderson, State Supt. of Education.

Mr. M. L. Meadors, Counsel, and Director of Public Relations.

Mr. Earl Britton, President of S. C. Federation of Labor.

Mr. R. C. Edwards, Pres. of Abbeville Textile Mills.

Mr. George Wilds, Pres. and General Mgr. of the Coker Pedigreed Seed Co., Hartsville.

Mr. W. W. Loran, Administrator or Supt. of Toumey Hospital.

Mr. J. D. Ashmore, Retail Druggist, in Greenville, dabbles at politics and a very prominent and public-spirited citizen.

The Chair: Do I get a second? (Dr. J. R. Young seconded the motion. A vote was taken and was unanimous and it was so ordered.)

The Chair: would like to recognize Mr. James Barnes, Executive Secretary of the Medical Association of the State of North Carolina, Mr. Barnes.

(Applause)

Are any of the fraternal delegates down from North Carolina, if they are I would like for them to stand. (No response).

The Chair: The Committee on Rural Health, Dr. H. S. Gilmore.

REPORT OF THE COMMITTEE ON RURAL HEALTH

Mr. President and Members of the House of Delegates:

As Chairman of the Committee on Rural Health of the South Carolina Medical Association, I had the pleasure of representing this Association at the National Conference on Rural Health, in Chicago, on February 4th and 5th, 1949. A report on this Conference appeared in the April issue of the State Journal (page 120).

I am happy to report that the only project the Committee on Rural Health undertook for the year has been successfully completed. That project was the formation of a State Health Council.

On November 17, 1948, after considerable preliminary work, The South Carolina Health Council was formally organized by the adoption of a Constitution and By-Laws and the election of officers and a Board of Directors. On February 17, 1949, the Health Council was issued a charter by the Secretary of State.

We have a far-reaching list of general objectives. However, our immediate objectives are four:

1. The expansion of sound prepayment plans for medical and hospital care for rural as well as urban citizens, and also the study of plans to care for the medically indigent.
2. The promotion of the recruitment, education and training of qualified young men and women in the field of nursing, and the establishment of scholarships for nurses' education.
3. The promotion of development of hospitals and health centers in areas needing these services.
4. Encouraging the administrators of teachers' colleges to add courses in health education in the college program which will give prospective teachers an adequate understanding of a good school health program and ways of putting such a program into effect.

We solicit the action and influence of each member of this Association in our endeavor to accomplish these objectives.

H. S. Gilmore, M. D., Chairman,
Committee on Rural Health
A. W. Browning, M. D.
M. J. Boggs, M. D.
J. A. Hayne, M. D.

THE SOUTH CAROLINA HEALTH COUNCIL: WHAT IS IT?

Whereas, the South Carolina Health Council was sponsored by the South Carolina Medical Association, through its Committee on Rural Health; and, whereas, so few members of the Association know the aims and purposes of the Health Council, I have resolved to set forth the objectives and other information concerning the Council so that you may be better informed about its set-up and what we propose to do.

Objectives of the Council, as adopted in the Constitution, are as follows:

1. To strengthen, through united support, a full health program for the State.
2. To serve as a clearing house on health and medical care problems and programs.
3. To assist in the elimination of duplication and overlapping of efforts, when practicable.
4. To bring together local and statewide organizations, agencies and individuals to facilitate joint planning where needed, and for special joint efforts.
5. To stimulate creation of a County Health Council in each County of the State.
6. To support specific programs directed toward:
 - a. Control and prevention of communicable diseases such as tuberculosis, venereal disease, infantile paralysis, and other communicable diseases which menace the health of the public.
 - b. The early diagnosis, treatment and care, when necessary, of patients suffering with non-communicable diseases such as rheumatic heart disease, cardio-vascular-renal disease, diabetes, and other diseases which affect large numbers of our citizens.
 - c. Increased maternal health services including prenatal, delivery and postnatal care, and the expansion of planned parenthood; and pre-marriage and marriage counseling programs.
 - d. Increased child health services, including medical examinations of pre-school and school children, dental programs, the correction of remediable handicaps, and immunization programs.
 - e. The promotion and expansion of nutrition education.
 - f. The study of eugenics in relation to hereditary illnesses and diseases, and the support of programs to alleviate these conditions.
 - g. Maintaining approved standards for the institutional care and treatment of the mentally ill and the epileptic, and for the training of the mentally deficient; the promotion of research and study as to the cause of mental disease and defect, and the provision of facilities for prevention, early diagnosis and treatment.
 - h. The support of the Medical College of South Carolina and the further development of education for all health personnel.
 - i. The promotion of development of hospitals and health centers in areas needing these services.
 - j. Securing more practical experience for nurses in the care of communicable and mental diseases.
 - k. Increasing the number of medical scholarships for young physicians who will practice in rural areas, and the encouragement of plans for rural communities which will make rural practice more attractive.
 - l. The promotion of recruitment, education and training of qualified young men and women in the field of nursing, and the establishment of scholarships for nurses' education.
 - m. The provision, education and training of adequate sanitary engineering, sanitation, dental and pharmaceutical personnel within South Carolina.

- n. Encouraging the administrators of teachers' colleges to add courses in health education in the college program which will give prospective teachers an adequate understanding of a good school health program, and means of putting such a program into effect.
 - o. The expansion of some prepayment plans for medical and hospital care for rural as well as urban citizens, and also the study of plans to care for the medically indigent.
 - p. The education of the public in regard to the foregoing and other health needs and facilities, and encouragement of continued improvement in the health education programs of the State.
 - q. A study of the quantitative and qualitative health and hospital personnel situation in South Carolina in relation to comparative salary and wage scales, and the correction of possible defects in this situation.
 - r. The encouragement of research regarding the health and health needs of the State.
 - s. The support of legislation toward the ends outlined herein.
 - t. The adoption of other specific programs and projects from time to time, as the changing needs of the State may require.
7. The Council shall assist the individual member agencies with their separate and specialized health programs, without attempting in any way to absorb, direct, or control any of these agencies in their particular fields, or in their fund-raising programs. The purpose of the Council is not to establish a competitive health agency, but to develop, through mutual agreement and planning, concerted effort in these special fields and in an overall health program in the State.

Membership

1. There shall be two representatives on the Council from statewide member agencies and organizations, and one representative from other organizations, which have been accepted for membership and wish to support the objectives of the Council.

2. The agencies eligible for representation in the Council shall be (1) those whose functions are entirely concerned with health and medical care, and (2) those organizations and agencies which have indicated a continuing interest in health and medical care and which, usually, have strong health committees.

3. Interested individuals may also apply for membership-at-large in the Council.

4. Organizations and individuals shall apply for membership in the Council in writing, and such applications shall be submitted to a membership committee, which will present the applications, with their recommendations, to the Executive Committee for election.

Dues

Membership dues, while not required for membership in the Council, or participation in the activities, should be the responsibility of membership agencies, organizations, and individuals, according to their ability to provide support for an effective joint expansion of the health and medical care programs and services in the State. The amount of contributions of any agency, organization or individual shall in no way determine the emphases, activities or limitations of the Council.

<i>Suggested Membership Dues</i>	<i>Annual</i>
Individual Members -----	\$ 1 or more
Local Agencies or Organizations ---	5 or more
State Agencies or Institutions ----	50 or more
Statewide Organizations -----	100 or more
Contributing Members -----	500 or more
Sustaining Members -----	\$1,000 or more

Immediate Objectives

Our immediate objectives are Nos. 6 (i), 6 (l), 6 (n), and 6 (o), of the General Objectives on Page 1.

Officers

Dr. Harold S. Gilmore, Nichols -----Chairman
Miss Katharine Edwards, Greenville

1st Vice-Chairman

Mr. O. G. Dorn, Sumter -----2nd Vice-Chairman

Mr. M. L. Meadors, Florence -----Secretary

Mr. R. L. Dougherty, Columbia -----Treasurer

Executive Committee

Miss Isadora R. Poe, Greenville

President, State Nurses Association

Miss Juanita H. Neely, Rock Hill

State Home Demonstration Agent

Mr. Thomas D. Wyatt, Spartanburg

Representative of State Board of Pharmacy

Mr. E. H. Agnew, Anderson

Representative of State Farm Bureau

Dr. C. L. Guyton, Columbia

Representative of the Hospital Division of State Board of Health

Mr. W. W. Lowrance, Sumter

Representative of State Hospital Association

Mr. Earle R. Britton, Columbia

President, South Carolina Federation of Labor

Mr. W. C. Bunch, Charleston

Representative of Charleston County Health Department

Mr. George A. Buchanan, Columbia

President, South Carolina Hospital Service Plan

Dr. W. J. Snyder, Jr.

Representative of South Carolina Medical Association

Harold S. Gilmore, M. D.

Chairman, South Carolina Health

Council

The Chair: The Committee Report on Medical Care of Veterans, Dr. C. N. Wyatt.

Dr. Wyatt: No one has objected to any of the fees, therefore my report will be a very short one. We have a recommendation that our contract be renewed by the Veterans Administration, under the present schedule.

The Chair: Report of Committee on Hospital Service, Dr. Robert Wilson, Chairman.

REPORT OF COMMITTEE ON HOSPITAL SERVICE PLANS

As time goes on and there is more and more agitation for governmental control and compulsory insurance for all of the costs of medical care, it becomes more and more apparent to your Committee that the only way organized medicine can meet the challenge and can maintain its independence as a free enterprise is by further encouraging voluntary insurance of all kinds.

We do not feel that the present Blue Cross plan as operated in South Carolina is by any means perfect in all respects but we do think that it gives the insured the most complete coverage at the lowest rates. And we further feel that changes in the plan should be made until all hospitals in the state feel that they can subscribe to the plan so that everyone desirous of obtaining this type of insurance can do so. We feel that every effort should be made to encourage co-operation between the directors of the plan and the hospitals until acceptance by all is an accomplished fact.

Some professional groups, notably the radiologists and the anesthesiologists, have not been completely happy under the plans for hospitalization and we suggest that these professional groups be considered as belonging to the proposed Blue Shield Plan when this is in operation.

Your committee feels definitely that encouragement of voluntary insurance of all kinds is essential to combat compulsory insurance and state regimentation and even if some parts have to be compromised in effecting voluntary plans it would certainly be worthwhile for the profession to do so and not have state regulations thrust upon us. Although the costs of medical care are already high in all probability they will go even higher, until they are really beyond the reach of most individuals in ordinary circumstances, and only by the insurance plans can the cost of such care be met. For this reason it is imperative for the medical profession to give encouragement to all of these endeavors.

Robert Wilson, Jr., M. D., Chairman
H. H. Addestone, M. D.
J. G. Seastrunk, M. D.
D. Lesesne Smith, M. D.

The Chair: Since the report carries no recommendation it will be accepted as information, unless there is some objection.

The next is the Report of the Committee on Industrial Health.

Dr. Harry Wilson, Chairman was prevented from being here today and his report will be presented by *Dr. J. G. Murray.*

Dr. Murray.

REPORT OF COMMITTEE ON INDUSTRIAL MEDICINE

Mr. President, Members of the House of Delegates of the State Medical Association:

This is the second annual report of the Committee on Industrial Medicine.

The members of this Committee are as follows: Dr. J. G. Murray, Greenville; Dr. G. P. Richards, Charleston; and Dr. Harry F. Wilson, Columbia, Chairman.

In view of the fact that this Committee is relatively new, it is considered advisable to enumerate the essential functions of State Committees on Industrial Medicine or Health:

1. To inform Industry and Labor of the value of industrial health conservation.
2. To develop a clear understanding of the proper scope and functions of industrial medicine, and to clarify relationships between private and industrial practice.
3. To keep the medical profession informed of all accepted methods for reducing the frequency and severity of industrially induced disability.
4. To elevate medical relations under Workmen's Compensation.
5. To scrutinize all legislation affecting the health of industrial workers.
6. To improve relationships between medicine and insurance.
7. To establish working relationships with all agencies in the State interested in industrial health.
8. To arrange for the adoption of similar activities through cooperating committees in the medical societies of the industrial counties.

Your Committee is giving considerable thought and consideration to several problems dealing directly with industrial medicine. At the present time the Industrial Commission has a medical examiner on a part-time basis. It is the opinion of your Committee that the medical examiner for the Industrial Commission should be on a full time basis. For your information, the Council of the State Medical Association appointed a

committee to meet with members of the Industrial Commission for the purpose of discussing the fee schedule for medical and surgical services. A report of the activities of this committee will probably be included in the report rendered by the Chairman of the Council. An occupational disease bill was introduced in the State House of Representatives recently. This bill received a favorable report by the Judiciary Committee. If passed, occupational diseases would qualify disabled industrial workers for Workmen's Compensation in this State, provided the disability was due to the individual's occupation.

Your Committee is of the opinion that no physician can serve the best interests of the employees and management without a thorough knowledge of industrial processes and environmental conditions which have direct relationship to the health of workers. He owes a responsibility to those he serves, to acquire knowledge of working conditions, and assist in all phases of the industrial health program intended to prevent injury and lessen the consequences of illness through exposure to industrial hazards.

In order to accomplish the above, it is believed that physicians and surgeons doing industrial medicine will find the following three publications interesting and informative: INDUSTRIAL MEDICINE, published monthly by Industrial Medical Publishing Company, 605 North Michigan Avenue, Chicago, Illinois; OCCUPATIONAL MEDICINE, published monthly by the American Medical Association, 535 North Dearborn St., Chicago, Illinois; and THE JOURNAL OF INDUSTRIAL HYGIENE AND TOXICOLOGY, published bi-monthly by the Williams and Wilkins Company, Baltimore, Maryland.

There is attached to this report a list of textbooks and publications that the industrial physician will find useful in his or her practice.

The management of industrial plants can frequently see the necessity, or even the advantage, of employing a nurse to render first aid to their employees, but they often are opposed to employing a physician, even on a part-time basis. They expect, and often demand, that the nurse assume all responsibility for the first aid and subsequent medical and surgical care of all their employees. This is unfair to the nurse and dangerous to all concerned. Especially is this true in removing corneal foreign bodies.

The nurse may give first aid but she has no right to give subsequent treatment unless the patient has been seen by a physician. She is practicing medicine if she does so. It is absolutely wrong to work as an industrial nurse in any manufacturing plant, or other business organization, where there is no physician in charge or on call. It is the duty of the nurse to have a definite understanding regarding this problem, before accepting a position. She should explain to the employer the danger if an accident happens and no arrangement has been made for medical care, and the danger to herself, of being charged with practicing medicine illegally.

A nurse in an industrial plant will be called on to make many independent decisions. For her own protection, she should keep some good rules in mind. One, never give medicine to an employee unless the plant physician has authorized medication in the event of certain contingencies, such as a certain drug for headache, or such and such drugs for painful menstruation. Two, where many women are employed the nurse may be asked for contraceptive information. The best policy is don't give it.

The Industrial Health Committee of the State Medical Association of Wisconsin prepared and published, in February 1948, a pamphlet on Industrial Health—*A guide for Medical and Nursing Personnel*. One section of this publication is devoted to standing

orders for nurses in industry. Your Committee does not feel justifiable in preparing a similar publication for the approximately 140 industrial nurses that are employed on a full-time basis in this State. Your Committee believes that if there exists a requirement for standing orders for nurses, it is the responsibility of the plant physician, whether he be full-time or part-time.

Industrial medicine appears to be approaching maturity but, as yet, the ultimate pattern has not become fixed. At the present time, medical and allied professions are in a position to assume leadership in this field. If this is to be done, it will be necessary to have a clear idea of the objectives of industrial medicine, as well as methods of obtaining these objectives.

The Chairman wishes to express his appreciation to other members of the Committee for their assistance and cooperation.

Respectfully submitted,
Harry F. Wilson, M. D., Chairman

The Chair: Council appointed a special committee to meet with the Industrial Commission to consider the fee schedule. Dr. Warren White headed that committee and will present his report.

REPORT OF THE FEE SCHEDULE COMMITTEE

To the House of Delegates and Council of the South Carolina Medical Association
Meeting at Myrtle Beach, May 17-19, 1949.

After being supplied with various fee schedules by Mr. James J. Reid, Chairman of the State Industrial Commission, the undersigned Fee Schedule Committee came to the unanimous agreement that the fee schedule worked out by the Workmen's Compensation Board of the State of New York was by far the best and would adequately serve with some modifications our purpose here in South Carolina. It was obvious that much time had been spent in preparing this excellent schedule and that a few modifications only would be required for its use here in South Carolina.

It was felt that the medical fee schedule could be accepted almost in its entirety without modification but that the surgical charges in view of the prevailing general lower rate in South Carolina should be reduced throughout the schedule by twenty-five percent (25%). This seemed to be appropriate in all departments of surgery including the various specialties. It was felt, however, that it would be better to make separate charges for after-care as is being done now on our State Form #14.

Dr. Augusta Willis of Orangeburg stated that she did not feel justified in agreeing to the radiological schedule without further consulting her State organization but thought that it would be just about the same as in this schedule. She is to send it in as soon as possible.

Respectfully submitted,
J. Warren White, M. D., Chairman
Roderick MacDonald, M. D.
Augusta E. Willis, M. D.
Henry F. Hall, M. D.
Edward F. Parker, M. D.

April 28, 1949

FEE SCHEDULE COMMITTEE MEETING

Held in Mr. Reid's room, Wade Hampton Hotel, April 21, 1949.

All Committee members were present along with Mr. McKenzie and Mr. Bywater.

Discussion of the establishment of a Panel of Physicians for the care of Industrial Commission cases was held and after it was found no agreement could be reached, it was decided that no recommendations should be made. Drs. Willis, MacDonald, and Hall felt that the establishment of a list (the use of the word Panel was felt to be bad) would not be accepted

by the profession at large (of particularly qualified physicians). It was held to be correct that the insurance carriers were justified in having their own physicians.

Information about the possibility of Dr. Dove succeeding Dr. Sawyer as consultant was received, but in view of no knowledge of Dr. Dove's qualifications no recommendations were made.

Mr. McKenzie discussed Form #14 and requested more information be given under remarks, particularly as to whether a patient has reached maximum recovery. It was suggested therefore that another inquiry be added to the form in order to bring out more definitely the information desired.

It was further suggested that the Commission from time to time send out letters to the doctors taking care of their cases calling attention to failures of omission or commission and would be useful to bring out other pertinent information.

As regards the fee schedule, it was felt that the New York Schedule could be used as a guide for a South Carolina Fee Schedule.

By and large the same fees were felt to be in order except that the operating fees which in the New York Schedule included a certain amount of after care should be reduced twenty-five percent (25%) but that the usual (at present in effect) after care visit be added. The other charges, such as medical, should continue as they are, both as regards general practitioners and internists fees. Injections, allergies, anaesthesias, and dermatological charges when made by properly qualified physicians should be continued as in the New York Fee Schedule. E. E. N. & T. should continue on the same New York Fee Schedule except for operative work which charges should be reduced twenty-five percent (25%) but after care added as is done at the present time.

Dr. Willis is to present a separate fee schedule after presenting the matter to her State Society and will communicate with me shortly; the schedule will be a little higher probably than the one in use at present due to the tremendous cost of materials.

In neurology, psychiatry, and neurosurgery the consultation charges are to remain as is but surgery fees to be reduced as in other specialties twenty-five percent (25%) but postoperative fees to be added.

Dr. R. B. Durham (Resumes The Chair): You have heard Dr. White's recommendations. I should think that the House of Delegates should approve this fee plan, if they so see fit.

Motion—By Dr. Weston, Sr.: I move its approval and thanks to the Committee for their work.

(This motion is seconded by Dr. Haynes; it was voted on.)

The Chair: The "ayes" have it, it is so ordered.

The Report of Committee on Maternal Welfare—*Dr. J. D. Guess.*

Dr. Guess: The degree of attainment can only be considered at the starting point. The action of the House of Delegates, already this year, and the action of the House of Delegates for the past few years has set South Carolina apart in its progressiveness. We had a long ways to go. You are the last State in the United States to set-up this plan, which we have just adopted.

Our Committee, you activated a committee last year, (you took a forward step) this committee has worked and is working. In the past and in the future you will find more in the Journal, progress reports, discussing various things that come up in our work. Those of you interested in obstetrics will find those reports helpful and interesting.

I wish to thank you members of the Committee on Maternal Welfare, and the doctors who have reported

deaths during the activity of this Committee, for their fine cooperation and particularly I wish to thank the MCH Division of the State Board of Health for helping us with clerical help, postage, stationery, a meeting place and many, many other ways, a help that has made it possible for us to go ahead without calling on the treasury of the South Carolina State Medical Association for funds.

REPORT OF COMMITTEE ON MATERNAL WELFARE

SOUTH CAROLINA MEDICAL ASSOCIATION 1949

The Committee on Maternal Welfare was completed late in the summer of 1948. It began to work shortly after. Its task was conceived to be three-fold, namely, statistical study of maternal deaths, educational efforts directed toward the profession and education of the laity in matters relating to childbearing.

Maternal deaths have been intensely studied by the committee. The study is accomplished in three steps: a copy of the death certificate is secured from the Bureau of Vital Statistics; a simple questionnaire is then sent to the attending physician requesting a brief history of the case; finally, the committee in open meeting discusses the various aspects of the case, and attempts to ascertain whether or not the cause of death has been correctly given, what factors, such as kind of medical treatment, hospital availability and efficiency, ignorance of the patient, economic status, and previous health of the deceased, might have been responsible for the death, and whether or not the death could have been prevented had these factors been different.

To date, work on professional obstetrical education has been limited to a personal letter to each reporting doctor giving an abstract of the Committee's discussion of his case, and its decisions. Related to this, there has been a paper prepared for, and delivered before, the obstetric seminar at the University of Georgia Medical School, and which was published in *The Journal*. This was a review of the work of a previous similar committee and its findings and a discussion of the fall in maternal mortality which were in the main the result of its activities. Further plans for extending the professional educational phases of its work are still in the primitive stage.

Even less has been done regarding the third phase of its activities, namely lay education. Two releases have been prepared for the daily and weekly newspapers of the state. Some papers used these. Further plans to extend this part of the work are in the making.

Fine cooperation has been given by the personnel of the M. C. H. Division of the State Board of Health, by the personnel of the County Health offices who have been asked for assistance, and by the great majority of reporting doctors.

The findings and conclusions of the Committee can be summarized only:

1. Many death certificates are made out hurriedly, carelessly, and inaccurately.
2. Most questionnaires are filled out honestly and in a spirit of cooperation, some are filled out carelessly and disinterestedly, a few are filled out defensively and do not correctly state the facts. It has been impossible to secure any replies from a few doctors in the State.
3. Hospitalization has been resorted to far too late in most instances of deaths in hospitals, thus not only resulting in death of the patient, but in over burdening personnel and facilities of the hospital to no avail. At times the delay appears to be due to inertia of the doctor or the public

health clinic examiner. Many times it has been caused by the ignorant refusal of patient or family. At times it has been caused by failure of county officials to provide an adequate, rapidly efficient system of hospitalization for emergency indigent patients. This is especially true where there are not county or other public hospitals within the county. At times delayed hospitalization seems to have been caused by a failure of the attending physician to recognize the signs of eminent serious complications or to consider the condition which later caused death a serious illness.

4. The miles to traverse to reach a hospital is not a measure of the availability of the hospital. At least three mothers died last year who lived within 18 miles of a hospital, but whose homes were isolated from physician and hospital by impassable roads and lack ? ? ? ? ?
5. Medical observation differs from medical care and at times both physicians and public health clinics have failed to move from the passive to the active, until mild disorder had become fatal illness.
6. Hospitals are in many instances inadequately prepared to administer blood transfusions promptly and in sufficient amounts. This was responsible for maternal deaths last year.
7. Surgical treatment of eclampsia still is practiced in the state.
8. Knowledge of causes of, and how to treat postpartum and abortion hemorrhages and facilities for the home emergency treatment of these conditions is far from universal.
9. Deaths from puerperal sepsis are probably continuing to decline. There is a tendency incorrectly toxemia, hemorrhage and other complicating toxemia, hemorrhage and other conditions.
10. The negro receives more hurried and more careless treatment than the white patient, but most of the time this is due to her ignorance in applying for it, her refusal to follow instructions, and to a feeling of futility produced in the doctor by this ignorance and lack of cooperation.
11. Although the state undoubtedly needs more hospital beds and a better distribution of doctors, it needs equally as badly a greater sensitivity by the political authorities to the needs of the medical indigent for prompt hospitalization at public expense in case of emergency sickness. Neither the doctor, the private hospital, nor the public hospital can assume the financial burden of these unfortunates, and delays in securing authorization results in needless deaths, or needlessly prolonged hospital stays.

The chairman wishes to express his appreciation to the other members of his committee, to the M. C. H. Division of the State Board of Health, and to the doctors all of whom have cooperated in such a fine manner to make the work of the committee possible.

J. Decherd Guess, M. D.
Chairman

The Chair: The next report is that of Committee on Public Relations, Dr. O. B. Chamberlain, Chairman.

REPORT OF COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations has kept closely in touch during the year with the work of the office of the Director of Public Relations and Counsel. The

scope of the duties of the office has been even wider and more general this year than in the past.

There was no special project on foot, such as the Board of Health study, during the previous year, or the promotion of special State legislation in which the profession is interested, as has been the case in other years. It is well that this was true, since the renewed and determined effort of the advocates of National Compulsory Health Insurance has required a vast amount of additional effort in opposition.

Our activities in this connection have been carried out by the State office both independently and in co-operation with the National Education Campaign of the American Medical Association.

It is, of course, also true that as the work of the office continues, new duties and responsibilities of a more or less routine nature are being accumulated. All of this has served to bring the Association's program more clearly and forcibly to the attention of the public, and your Committee feels very definitely that the favorable effect is increasing steadily.

In January, the Council held a specially called meeting to hear reports from the officers who attended the interim session of the American Medical Association in St. Louis, and to consider what steps should be taken by the State organization in regard to the national emergency which appeared to be imminent. After considering several suggestions, Council appropriated to the budget for Public Relations, an additional sum of \$5,000, or so much thereof as should be necessary, for the current year, for the expansion of activities in this field, including, when necessary, the employment of additional personnel, under the supervision of the Director of Public Relations and the Association's Secretary.

Important emphasis is being placed by the national organization upon the sale of voluntary health and hospital insurance, both the conventional type and under the non-profit plans, as a positive effort at solution of the problems of medical care, in a manner consistent with our present system of practice.

With this movement your Committee is thoroughly in accord. We hope that the proposals which have been made by the Committee on Medical Service for a Prepayment Medical Care Plan in South Carolina will receive favorable consideration by the House of Delegates. South Carolina is far behind the other states in this matter and without definite endorsement and promotion of some plan of this kind, it will be hard for the medical profession of the state to justify its opposition to the proposals for compulsory government insurance.

In this connection we would like to call attention to one feature of the health and hospital insurance policies now in current use which presents a very real difficulty so far as mental and nervous diseases are concerned. Most policies with which we have had any dealing make no provision for professional services or hospitalization in connection with mental and nervous ailments, except when these conditions are connected with or attributable to some physical injury or impairment. This, of course, discriminates to some extent against the physicians treating these particular types of diseases and tends to lessen the facility of such patients to obtain adequate professional service and hospitalization. It has still a further disadvantage. There is a natural tendency among some physicians, with what, perhaps, is a worthy motive, to assist the patient whose case otherwise would not be covered, by making diagnosis of some physical condition entitling the policyholder to professional service or hospitalization, which diagnosis may not be entirely accurate.

While we realize that there is no present effort on the part of the Association to cover any type of professional service except in connection with surgery and obstetrics your Committee believes that we should exert our influence toward bringing about proper changes in the provisions of policies of the conventional type and also perhaps the Blue Cross contract.

In view of all of the foregoing observations, therefore, your Committee respectfully recommends:

First: That the activities of the office of the Director of Public Relations and Counsel be set up as a separate department of the activities of the South Carolina Medical Association, to be designated as the Department of Public Relations or by such other name as Council may determine, with a separate budget for such Department under the executive direction of the Counsel and Director of Public Relations, who shall be directly accountable to and under the general supervision of the Committee on Public Relations of the State Association.

Second: That the proposed organization, extent and types of coverage, and method of operation of the prepayment medical care plan as proposed and recommended by the Committee on Medical Service, be approved and adopted as a vital part of our public Relations Program and that the members of the Association co-operate fully with the plan as individuals through participation where possible, and at all times with their influence and moral support.

Third: That this Committee or a separate Committee to be appointed by Council be authorized to study fully the provisions of insurance contracts now being offered the public in South Carolina and to confer with the Insurance Commissioner of South Carolina, with a view to having included in such contracts provisions for coverage in the case of mental and nervous diseases, and toward standardizing the phraseology and provisions for payment in such cases.

Respectfully submitted,
Olin B. Chamberlain,
Chairman.

The Chair: Thank you Dr. Chamberlain, I am going to refer that to the Committee on Resolutions, Dr. Young, Chairman, Dr. Brockman and Dr. Pressly, and I would ask that they report back, after the short recess which will be granted.

The Chair: The report of Committee on Recruiting Nurses—Dr. Coyt Ham.

REPORT COMMITTEE ON RECRUITING OF NURSES SOUTH CAROLINA MEDICAL ASSOCIATION 1948-1949

Your committee met in Columbia, South Carolina late in the summer of 1948 for an all day luncheon meeting jointly with representatives from the South Carolina Hospital Association, The South Carolina League of Nursing Education, South Carolina Nurses Association, The South Carolina State Board of Examination and Registration of Nurses together with several other persons interested in the recruiting of nurses. At this meeting the existing situation was discussed fully. The ultimate consensus of opinion was that every effort possible should be employed to interest young high school graduates in nurse education. The responsibility to this end evolves on, not solely the medical and nursing professions, but on all who have the welfare and the improvement of health conditions of the citizens of our state at heart.

The educational directors and superintendents of nurses of the sixteen recognized and accredited Nurse Training Schools in South Carolina, in the past have assumed the responsibility for stimulating interest in nurse education. The problem of caring for the sick

has increased within recent years and will continue to increase in the same relative proportion as our social and economic status improves. Nurse education must improve and increase as we progress in other modes of life. The medical profession as a whole can render inestimable assistance by bringing well qualified young women in contact with the schools of their choice.

Commendation is given to the South Carolina Hospital Association for the active and aggressive part that this organization has played and the fine methods employed in bringing the urgency of the shortage of nurses in training to the public. Likewise sincere appreciation is expressed to the Auxiliary, Columbia Medical Society, for assuming as one of their major projects the recruiting of student nurses. The Auxiliary, South Carolina Medical Association through its other chapters can be of much assistance. To other groups that have not come to our attention that have rendered assistance in any way, our consideration is given and their continued efforts are solicited.

Your committee earnestly requests the South Carolina Medical Association to continue its support and to give freely, wise council until the high standard of nurse education in the state will be second to none, meeting standards as prescribed by the National League of Nursing Education.

Respectfully submitted,
Coyt Ham, M. D., Chairman
Gertrude Holmes, M. D.
Vince Moseley, M. D.
(Recess—5 minutes)
(After the Recess)

The Chair: We will have the Report of Committee on Resolutions, *Dr. J. R. Young, Chairman.*

Dr. Young: Two matters came before our Committee and I will take them up one at the time.

WHEREAS, the Presidency of the South Carolina Medical Association is a position of great honor and the expression of the highest esteem and confidence of the members of the South Carolina Medical Association, and

WHEREAS, It would seem fitting and proper that permanent recognition of these facts may be made matter of record,

THEREFORE: BE IT RESOLVED, that at the close of his term of office a gold medal be awarded of the size of a \$20.00 gold piece, upon which shall be inscribed the name of the Association, the name of the recipient and the date.

In view of the time it is not practicable to make this award at the present meeting, the award shall be made at the next meeting to the present incumbent. The Secretary of the Association is hereby instructed to make all necessary arrangements to carry out this instruction.

Mr. President, your Committee on Resolutions recommends the adoption of this resolution.

The Chair: You have heard the proposed resolution, do I hear a motion that it be adopted?

Dr. Julian Price (Recognized by The Chair): Might I make one word of explanation? Four years ago the Council instituted the custom of presenting a gift to the retiring president, as he went out of office. That has been done, the gift has been one that was thought to appeal to the President and in each instance the President's wife has been contacted and she has selected the gift. The last three years it was a silver platter.

The question is would you rather have the medal or continue the custom made four years ago?

Motion:—*Dr. R. L. Crawford:* I move that we adopt the resolution as read by Dr. Young.

(This motion was seconded by Dr. Jack Parker)

Dr. Wm. Weston, Sr. (Recognized): Regardless of the decision of Council, I do not question its wisdom, I think this award is entirely proper, it is one that has certainly been most effectual in the American Medical Association and other associations, such as the American Academy of Medicine and others, and I hope this resolution will be adopted.

The Chair: Is there any further discussion? If not, all in favor of this resolution, signify by saying "aye". All opposed "no". The "ayes" have it and it is so ordered.

Dr. Young (Chrm. Resolutions Committee, continues): The other matter that came up before the Resolutions Committee was the report as read by Dr. Chamberlain, the last paragraph of that, I will read it. "That this Committee or a separate Committee to be appointed by Council be authorized to study fully the provisions of insurance contracts now being offered the public in South Carolina and to confer with the Insurance Commissioner of South Carolina, with a view to having included in such contracts provisions for coverage in the case of mental and nervous diseases, and toward standardizing the phraseology and provisions for payment in such cases."

Your Committee on Resolutions recommends to the House of Delegates that that be adopted.

The Chair: Do I hear a motion to that effect?

(Motion is made by Dr. William Weston, Sr., and is seconded by Dr. Brockman. There was no discussion, the motion was put and was unanimously carried.)

It is so ordered. (Dr. Young stated that completed his recommendations and the Chair thanked the Committee.)

The Chair: Report of Special Committee on Basic Science Law, *Dr. J. H. Stokes, Chrm.*

REPORT OF SPECIAL COMMITTEE ON BASIC SCIENCE LAW

This committee met on four occasions during the year, one meeting being held with the Board of Medical Examiners. It was the unanimous opinion of the Committee that a Basic Science Law be adopted. This law is patterned after that now in vogue in many states and the contents of the act will give in more detail the organizational set-up. It is the opinion of this committee that the passage of such an act is the only feasible manner of combatting the influx of charlatans who propose to practice the healing arts.

(Applause)

The Chair: Gentlemen, You have heard the Report of Chairman Stokes, what is your pleasure in this matter.

Dr. N. B. Heyward (Recognized): There is no motion before the house, I would like to discuss that.

The Chair: You have the floor.

Dr. N. B. Heyward: Your Board of Medical Examiners have been fretting over this Basic Science Law for some years. A casual observation, it would look like "Well, that sounds ideal." Take these boys and screen them through there and the poor medical men will be screened out, the naturopaths and the chiropractors will be screened out, and it sounded fine. With that in view we looked into the matter, we went into it from all angles. The first obstacles that struck us was to get somebody to get up a Board of that kind. It was suggested we get men from the University of South Carolina, Clemson, Winthrop, Furman. For the examination in anatomy, physiology, biochemistry, it looked like we were going to have to go into the medical school to get men to examine along those lines, that was wonderful. At the last meeting

this was presented, they had written various institutions for men who might be suited for it and for the four or five jobs that we could ideally use, they had relatively few men that could handle such a job. So, it will be a job to form such a board.

The next thing was an investigation of some of the other Science Boards. Apparently there are Basic Science Laws in 18 or 19 states. The personnel of those Boards; here is a resume, gotten out by the American Medical Association; in Connecticut, there are no doctors on the Board, but some professor in Chemistry handles that; in Michigan among the members is an osteopath and a chiropractor; in Minnesota, one doctor, one chiropractor, one osteopath and one veterinarian; in Nebraska, no doctors at all; in Oklahoma, one member was an osteopath, one a chiropractor, one appointed by the Governor and four members of the faculty of the University of Oklahoma.

In South Carolina we are going to have a chiropractor and an osteopath, and we are going to have a naturopath on such a board. If you don't think they are strong you go to the Legislature and try to fight them and go look them over and buck against them.

If you could get a nice high-class Board, with no politics, it sounds good, it is a good idea. But, listen to this, in the 18 Basic Science Boards in 1944, composed of naturopaths, osteopaths, chiropractors, some professional chemists and this, that, and the other, some few doctors, they flunked 18% of the medical men who took the examination. In 1945, 16.4 percent flunked it. In 1946, 18.7 percent flunked it. (Holding up a paper) Ideally it sounds fine, yes, it would be nice.

It was brought up in Council primarily to block the naturopaths, but you put in a Basic Science Law, where will it get you? We have got the naturopaths in South Carolina, we have got to get them out or do something with them, that was the idea of abandoning this plan and trying to take some of the powers away, it looks like we are not men enough to do it. We didn't have any luck this year.

South Carolina for some years has carefully picked, corresponded with and observed Boards of Medical Examiners and we have established reciprocity with 22 Boards over the United States, men we have seen and like them, and our reciprocity is very satisfactory. I don't know what we will do when we try to put in a Basic Science Law. We examined and admitted 56 boys by examination, we admitted 36 or 40 by reciprocity, we got some good boys by reciprocity. I don't know what the Basic Science Law will do to our reciprocity.

With young men studying medicine, they require so much of them, it will further discourage young men taking up medicine, with another road-block thrown in their way, now, to require a Basic Science Law. We need doctors in South Carolina, will we stop them coming in? Stop men coming in by reciprocity and discourage our young men? We don't think it wise. And in the small State of South Carolina it would be almost impossible to find necessary scientists to compose such a Board, without calling on the medical school.

The Board of Medical Examiners voted against this. It was brought to Council and Council wouldn't take a stand,—said the House of Delegates should pass on it. In the opinion of your Board, not entirely, some of them think they could do it, but the majority of the Board think it would be a mistake to undertake such a thing.

The boys will put it through the Legislature because I live in Columbia, I know, it is a job. If you get it, you will get a mixed board and your boys will have to pass the chiropractors', osteopaths', and

naturopaths' examinations as sure as I am standing here, that is the reason I am opposed to it.

The Chair: What does the House of Delegates wish done with Dr. Stokes' report?

Dr. Hope: I move you, sir, the House of Delegates accept the Report of Dr. Stokes as information and thank the Committee for the work they have done. I do that for this reason,—at the present time it seems to me they are too mixed up with what we wish to do with keeping out the Naturopaths, and it has got to be done through legislative channels. I am quite convinced the Basic Science Law is not the final say-so in this matter and, therefore, I move you, sir, we accept the report as information.

(This motion was seconded by Dr. Brockman)

(It was also seconded by Dr. Adcock)

The Chair: Is there any further discussion?

Dr. Brockman: I want to say this, I wish I knew the answer to this question. Those of us that live in the Piedmont and see these various cults being recognized by a gullible public, they think they are just on an equal with a reputable physician and they are doing a lot of harm. They have almost got as good a license as we have, the only little thing they didn't slip into that license, if any of you have ever read it, they can't practice medicine and they can't do general surgery but they can do nearly everything else that we can do.

Several of us in Greenville have seen some horrible things happen and the public wonders why we physicians don't do something about it. They say "Why do you doctors allow this?" And we say, "Why we knew nothing about it. That thing was slipped in, we didn't know it until it was in, until they had a license."

I am going to relate just one of many things I have seen. I went into an operating room of one of our hospitals one day and I found everybody racing around and I found a nice eye, ear and nose doctor in there in distress, trying to stop a hemorrhage, that had been caused from some of this injection of tonsils by one of these naturopaths, and he needed all the help that all of us could give him because it looked like that patient, about 19, would bleed to death there on the table. He was cyanotic, and in shock, and nurses and everybody trying to aid in getting plasma into him while the doctor tried to get hold of the bleeder. This boy had been brought out of the mill, where this hemorrhage first occurred, and of course, the lapse of time getting him into the hospital, he was in great shock and lots of distress.

Those cases seem to be re-enacted over and over there in Greenville, they have injected hernias and broken off needles and then there is nothing to do but some general surgeon go on and take over. They have injected hemorrhoids and caused great hemorrhages; and they have injected veins and various things, they just do a lot of devilment and make a lot of money.

I believe the only thing, the only way a dignified society can handle this thing is through this Basic Science Law, if we put, as the committee has recommended, men out of our Universities on that Board, there won't be any chiropractors and there won't be any osteopaths on it.

I don't know the answer, but I know this Association is being expected by the people of South Carolina to do something to stop these rascals from practicing medicine, that is what they are doing at Travelers Rest.

We have got to take care of this situation, the responsibility is on us. But, if the Board of Medical Examiners, whom I respect, discredit this Basic Science Law, if they think that is wrong, then let's find some other good answer and get rid of it. These cultists are a reflection on us. Tennessee has turned

them loose on us. Other states have ruled them out with a Basic Science Law. I believe we ought to have that law or something else, some other good law.

Dr. Blake: At first blush you think the Basic Science Law is the cure for the evil. Frankly when I first thought of it, I was heartily in favor of it. I notice the Governor has the appointment of this Board. Who has charge of who is going to be Governor? Can you control them? No. So I feel very definitely that the Basic Science Law at this time is a very dangerous thing, and I am against it.

Dr. Adcock: There are two or three other points. If we are powerful enough to pass the Basic Science Law that we would desire, we should be powerful enough to write them off, just as is. Then, it does not eliminate these naturopaths that we have, which is quite necessary. Besides the percentage of loss of medical students in the examination, I think it would definitely upset a lot of our medical students, if we should get an osteopath or a naturopath or chiropractor placed upon our Boards. I am certain when I left the farm to take the Medical Board, if I had come up to a chiropractor I would say, "Let me go back."

The other thing we must think about is,—this would quite dignify the chiropractor and other cults to be taking the examination with our medical students.

Dr. Guess: Gentlemen, during Dr. Brockman's administration he became very much interested in the Basic Science Law. At first blush I thought it was the solution. I made considerable investigation of Basic Science Laws and their administration through the country and I became and am still opposed to it. I admit everything that Dr. Brockman and the other men say is true, and I want to add one other objection to our getting thru this Basic Science Law at this time. That objection is this—there are a large number of people in South Carolina and in this country who speak of "Medical Monopoly"; who feel we doctors are trying to prevent more doctors from entering into practice in this country, and this will give them more talking points, such as "The medical monopoly of South Carolina is advocating another examination, which the aspirant to practice medicine must pass before he can be licensed" and I think that is of importance, considerable importance.

Dr. Robert Wilson: We have had chiropractors for a long time and haven't done much about it. I think the influence of the naturopaths in this state has brought to the attention of the Association the possibility of a Basic Science Law, and I take it, because of the naturopaths (and the advocacy of this law is largely pointed at them,) I don't believe that law would get through.

I had a good many conversations about one year ago with members of the Senate and House Delegation from Charleston and I was told, on what I gathered to be good authority, that the Chairman of the Medical Affairs Committee had an uncle who was a Naturopath and under no consideration was this Chairman to let the bill go out of Committee. "If he ran his uncle out of business, he would have to support him." There is a lot of black — politics that we don't know about.

The efforts of this association should be made to make these people advertise themselves. They have made an "N" look like an "MD" and the people are fooled. I think that all our efforts should be directed not against that group but we should include ourselves in any regulation passed and I think if the physicians and chiropractors and naturopaths were made to advertise themselves for what type of practitioner they are, then the public could be free to choose,—and after all, the public has a right to make the choice. If they have no more sense than to go to a naturopath, that is their right and their privilege.

We can't knock any common sense into the head of the public.

Our efforts should be directed to the education of the public and not to the limiting of the practice. I will therefore vote for Dr. Hope's motion.

The Chair: Ready? All in favor of Dr. Hope's motion to accept the report of Dr. Stokes as information and thank the Committee for the work they have done, signify by saying "aye". Opposed "No".

(This motion was unanimously passed.)

The Chair: Just before the film starts, I would like to get the expression from the House of Delegates as to the advisability of a resolution, having our secretary wire each member of our National Congress that we go on record as opposing the Truman Health Program.

Dr. Stokes:

Whereas, under a system of free enterprise the American Medical profession has established the world's highest standards of scientific performance, treatment and research thereby helping the United States to become the healthiest major nation in the world; and

Whereas, the benefits of American medicine are available to the people of this country on a budget-basis, voluntary health insurance plan; and

Whereas, the experience of all countries where Government has assumed control of medical service has shown that there has been a gradual erosion of free enterprise and progressive deterioration of medical standards and medical care to the detriment of the health of the people; Now therefore

BE IT RESOLVED that the South Carolina Medical Association does hereby go on record against any form of compulsory health insurance or any system of political medicine designed for national bureaucratic control; and that a copy of this Resolution be forwarded to the President of the United States and a copy to each member of the National Senate and House of Representatives from South Carolina and that they be urged to oppose with all the strength at their command the pending bills and any proposal for such system of compulsory medical care.

Done and adopted at Myrtle Beach, S. C., this 17th Day of May, 1949.

Secretary

Dr. Dechard Guess: Mr. President, I move the adoption of the resolution.

(This motion was seconded by Dr. Geo. Johnson)

The Chair: Is there any discussion? If not, all in favor of this motion signify by saying "aye". Opposed "no". The "ayes" have it and it is so ordered.

Dr. Julian Price: Upon the instruction of Council, I am presenting the following suggested change in our Constitution. In view of our action today we are establishing a South Carolina Medical Care Plan, and since the Board which controls that must of a necessity be in close contact with the House of Delegates and with the Council, your Council is suggesting the following amendment to our Constitution: Changing Article VI of the Constitution to read:

Article VI—The Council shall consist of the Councilors, and the President, The President-Elect, and The Secretary of the Association, the delegates to the American Medical Association, and the President of the Board of Directors of the South Carolina Medical Care Plan.

That would simply mean that the President of the Board of Directors of the South Carolina Medical Care Plan would be a member of Council so that he could participate with the Council.

I move you, that that amendment be placed on the table for a year, subject to its final adoption next year.

(This motion was seconded by Dr. William Weston, Sr.)

The Chair: Is there any discussion?

Dr. Guess: Under the By-Laws that you have adopted today it is obligatory the President of the Board of Directors of the Medical Care Plan be a doctor member of that Board, so that the President will, of course, be a physician.

The Chair: Any further discussion? If not all in favor of the motion signify by saying "aye". Opposed "no". The motion is unanimously passed and it is so ordered.

The Chair: Appointment of tellers—

Joe Cain, Bob Hope, Spence McCants (Tellers).

Now, we will have the election of officers, First is President-Elect.

Dr. Clough H. Blake: I would like to nominate for the Greenwood Delegation a gentleman who has been in general practice for thirty-eight years. In that time he has served a large community and served it well. He is a man who has the absolute and perfect respect and love of all of his people. He is a man of the highest character and great attainments. In addition to that, through these thirty-eight years, unless it was a matter of health, I don't think he has missed a chance to participate in meeting with his brother physicians, especially in public meetings. I think he is one of the finest men we could possibly think of for President-Elect of the South Carolina Medical Association and the Greenwood Delegation wishes to nominate Dr. Wilbur R. Tuten.

(This Nomination seconded by Dr. Richard Johnson)

Dr. Workman: I wish to place in nomination the name of a native son of our State. After graduating from our Medical College and taking several years of post-graduate work he came to Spartanburg to practice. He has repeatedly served as Chief of Staff of the Spartanburg General Hospital and largely due to his efforts that hospital has been approved by A. M. A. He is director of the Cancer Clinic of our County, he has given his time freely, using his knowledge and skill and untiring efforts in relieving the suffering of these unfortunates. He has been Past President of the Spartanburg Medical Society, he is President of the Piedmont Seminar. He has held up the practice of medicine as opposed to socialized medicine and in the last War he heard the call of duty and he volunteered his services to his country and remained there until the cessation of hostilities, at which time he returned to his former work. This man is endorsed by every member of the Spartanburg Medical Society for the position of president-elect of this Association. We nominate Dr. John Fleming of Spartanburg as President-Elect of this Association.

(Dr. George Johnson seconded this nomination.)

Dr. Truluck: Dr. Tuten was endorsed by the 8th Medical District. He has been an outstanding doctor in the lower part of the State for 38 years. He has held all offices in the State and District, and has been on the State Board of Medical Examiners for the past ten years. It gives me pleasure as a member of the Orangeburg Society to second the nomination of Dr. Tuten.

Dr. H. W. Koopman: I would like to second Dr. Workman's nomination of Dr. John Fleming of Spartanburg because of close personal friendship and comradeship for 16 years and because of the achievements that Dr. Workman has stated and because he is a doer, he gets things done.

Dr. N. B. Heyward: It gives me great pleasure to second the nomination of Dr. Wilbur R. Tuten of

Fairfax. We know him in Columbia, I have seen him on the Board of Medical Examiners and he is a splendid physician and gentleman and will make a wonderful president of the South Carolina Medical Association.

The Chair: Are there any other nominations?

Dr. William Weston, Sr.: I move the nominations be closed. (This was seconded by Dr. Thaxton.)

The Chair: It is moved and seconded that the nominations be closed, all in favor signify by saying "aye". Opposed "no". The "ayes" have it.

Prepare your ballots for Dr. John Fleming and Dr. Wilbur R. Tuten for President-Elect.

According to the Credentials Committee there should not be over eighty-eight (88) votes.

Election of Vice President:

Nomination—Dr. R. C. Smith: I should like to put the name of Dr. Archie Sasser of Conway, up as Vice-President. He is well-known to you all, and he has a great deal of influence and respect and takes a great deal of responsibility in meetings of this area. He has been a grand doctor and a grand citizen of our community.

(The nomination of Dr. Archie Sasser for Vice-President was seconded by Drs. Dibble, Robert Wilson and N. B. Heyward.)

Dr. Dibble: I move the nominations be closed.

(This motion was seconded by Dr. Workman)

The Chair: All in favor of that motion signify by saying "aye". All opposed "no". The motion was carried unanimously.

(Dr. Sasser was called, but he was not in the meeting)

The Chair: There is hardly any use to vote on this next one. The election of Secretary-Treasurer. Do I hear a motion?

Dr. Smith: I move we elect by acclamation Dr. Julian Price, knowing he will be unanimously re-elected.

(This motion was seconded by Dr. Workman)

(The motion was voted upon and unanimously passed)

The Chair: It is so ordered.

Dr. Julian Price: I sincerely appreciate this. In December 1940 I was first elevated to the office of Secretary. I have held that office up to this time. I really appreciate the fact you have put up with me, I have had an awfully good time at the job. For various reasons, however, I feel it incumbent upon me to ask, as of our next annual meeting, that you select a new Secretary. I know it is for my own good and I feel it is for the best interest of the Association.

The Chair: We are entitled to two delegates to the AMA, both to begin their duties January 1st. Do I hear a nomination for Delegate to AMA?

Nomination—Dr. E. V. Poolc: I nominate Dr. Hugh Smith to succeed himself. (This was seconded by Dr. Jack Parker)

*Question—*Is it in order for the nomination of a second Delegate to AMA, now?

The Chair: Let's close this one, then we will take up the second one.

Dr. Pressly: I second the nomination of Dr. Hugh Smith, it has been my pleasure to be with him in Chicago and other places and he certainly represents us with a great deal of credit and he has much influence.

The Chair: All in favor of this motion signify by saying "aye". (Those opposed were called for but the vote was unanimously for Dr. Hugh Smith and it was so ordered by The Chair)

Dr. Robert Wilson: For the second delegate to AMA I nominate a man pre-eminently qualified to represent the Association in the councils of the AMA, Dr. Julian Price of Florence.

(This motion was seconded by Dr. Brockman.)

Dr. T. A. Pitts: Mr. President I want this body to consider a representative to the AMA, whom I think will serve us well; I say it with a lot of feeling because there are certain things which I will bring out in a few moments that I think will clarify my position. Certainly Dr. Julian Price knows very well that when I was president of this association that I thought enough of him to appoint him to serve and what I say is not detracting at all from Dr. Price's ability, his standing, or anything. But I do wish to say that Dr. William Weston, Jr., of Columbia has the possibilities of serving us in many ways. His illustrious father, as many of you know, has served as Delegate from the Section on Pediatrics for many years. He is the choice of the Section on Pediatrics, and I say with the knowledge of personal experience, that Dr. William Weston, Sr., today has as much, if not more voice and power in the American Medical Association, up there, as any man who belongs to that body.

Some years ago this body saw fit to choose me to represent them. Dr. Weston took me, the country boy from Saluda by the hand, he lead me through the by-ways and the high-ways of the AMA and finally gave me a glimpse of the inner sanctum, which I would not have been able to see had I served, alone, for a lifetime.

This position of father-son representation in the AMA is unique. It would give us that unique position. It would give us prestige, passed from father to son; it would give us a representation there the like of which we would not be able to get from any other source. So, without further fan-fare, I wish to place the name of Dr. William Weston, Jr., for your consideration.

The Chair: Do I get a second to that?

(Dr. N. B. Heyward seconds the nomination of Dr. William Weston, Jr.)

Dr. Workman made a motion that the nominations be closed, and this was seconded by Dr. Brockman.

This Motion was voted on and passed unanimously.

The Chair: Prepare your ballots for Dr. Julian Price and Dr. William Weston, Jr., for Second Delegate to AMA.

Election Result—President Elect:

Dr. Wilbur Tuten—55 votes

Dr. John Fleming—29 votes

Dr. Workman: I wish to make a motion that we make this election of Dr. Tuten unanimous and pledge him our usual whole-hearted support.

(The Entire House of Delegates rise to make the vote unanimous.)

Election of Councilmen—

The Chair: The next on the agenda is the election of Councilors for (3-Year terms). First, Chairman of Council, Dr. O. B. Mayer of the Second District.

Dr. Pitts: I should like to place the name of Dr. O. B. Mayer to succeed himself.

(This nomination was seconded by Dr. N. B. Heyward, who also made a motion that the nominations be closed. This motion was seconded by Dr. Dibble.)

President-Elect, Dr. Wilbur R. Tuten, your new President-Elect.

(Applause)

Dr. Tuten: I thank you gentlemen very much for this honor: I remember I am just an ordinary country doctor, and I mean "ordinary". This is not a position

which I sought, but I will give my best efforts to carry on and do the best I can. Thank you.

(Applause)

The Chair: All in favor of the motion for Dr. O. B. Mayer to succeed himself, signify by saying "aye", opposed "no", the Ayes have it and it is so ordered.

Fifth District (The term of Dr. C. S. McCants expires this year.)

Dr. Floyd: I would like to nominate Dr. C. S. McCants to succeed himself.

(This nomination was seconded by Dr. Winters.)

(Dr. N. B. Heyward moved the nominations be closed, which motion was seconded by Dr. Chapman.)

A vote was taken, it was unanimously carried and was so ordered.

Eighth District (The term of Dr. L. P. Thackston expires this year)

Dr. Truluck: I would like to nominate Dr. Thackston to succeed himself.

(This nomination was seconded by Dr. J. H. Danner.)

(Motion made by Dr. A. B. Preacher that nominations be closed, This was seconded by Dr. Winters; a vote was taken and it was unanimously in favor of Dr. Thackston to succeed himself and it was so ordered.)

State Board of Medical Examiners—First District (Term of Dr. A. R. Johnston expires this year)

Dr. Riddick Ackerman, Jr.: I would like to nominate Dr. A. R. Johnston to succeed himself.

(Dr. Truluck seconds this nomination and Dr. Van de Erve made a motion that the nominations be closed. It was voted and so ordered that Dr. Johnston succeed himself.)

Report of Tellers—Delegate No. 2, to AMA—

Dr. Weston, Jr.—37 votes

Dr. Price—41 votes

The Chair: We have a communication from Dr. W. W. Boyd, which will be read at this time.

"South Carolina Medical Association

Dr. Julian Price, Secretary

Dear Doctor Price:

Please accept my resignation as Councillor of the 9th District. Much to my regret I find it impossible to attend the meetings and to carry out the duties of the position.

Submitted by,

W. W. Boyd, M. D."

The Chair: We will have to elect somebody to succeed Dr. Boyd.

Dr. Copeland: I would like to nominate Dr. Lesesne Smith.

(This nomination was seconded by Dr. Workman, also by Dr. Hayne, and Dr. Floyd.)

(There were no further nominations and a vote was taken and passed unanimously.)

The Chair: Dr. Lesesne Smith takes Dr. Boyd's place, and takes up his duties as Councilor of the 9th District.

We will now revert to the State Board elections.

The Third District (The term of Dr. C. W. Blake expires this year.)

Dr. Heyward: I nominate Dr. C. W. Blake to succeed himself.

(This nomination was seconded by Dr. Adeock, also by Drs. Kirkpatrick and Pitts. A motion was made that the nominations be closed, which was seconded by Dr. Adeock. A vote was taken and unanimously passed, and it was so ordered.)

The Chair: The Nominations Committee for membership on The State Board of Health will put the names of the twelve men on the blackboard and we are to elect seven from the twelve. I will instruct the tellers to take the high seven out of that twelve.

The Chair: We will now hear from Dr. Archie Sasser, our Vice-President. (Applause)

Dr. Archie Sasser: Members of the South Carolina Medical Association, this is quite an honor and rather a surprise to me, and I realize the responsibility of any officer in any Medical Association during these times. I think that medicine now is on trial and it is an individual proposition, it is a proposition to every member in the medical profession because we are being watched by all of the left-wingers, including our politicians, and they are just waiting for a break to put us in the hole. I am going to try my best and I certainly hope I can benefit the Medical profession in some way. (Applause)

The Chair: While the Members of the House of Delegates prepare the ballots for the seven men on the Executive Committee of the State Board of Health, I think we will go ahead with the election of the Members of the Advisory Committee on Hospitals to State Board of Health, (5 year terms).

The Chair: Members of the Advisory Committee on Hospitals—Frank Cain and Jack Parker, their terms expire this year.

My secretary informs me we filled one of those places this morning with a colored physician. We only elect one (1) man, do I hear a nomination of one (1) doctor to succeed Drs. Frank Cain and Jack Parker?

Dr. D. O. Rhame: I nominate Dr. Jack Parker to succeed himself.

(This nomination was seconded by Dr. Brockman. Dr. Heyward made a motion that the nominations be closed and that Dr. Jack Parker be elected by acclamation. This motion was seconded and the vote was taken and the "ayes" were unanimous and it was so ordered.)

The Chair: Inasmuch as it is going to take some time to count the votes for the Executive Committee of the State Board of Health, we will go forward with our business.

The Chair: The next is the selection of a place for the 1950 Annual Session—Do I get an invitation?

Dr. D. O. Winter (Recognized): I have a communication from the Sumter County Medical Society, which says:

May 16, 1949

House of Delegates
South Carolina Medical Association
Myrtle Beach, S. C.

The Sumter County Medical Society, which is a combination of Sumter, Clarendon, and Lee Counties, together with the other county medical societies of the 7th district, i.e., Williamsburg and Georgetown, take pleasure in inviting the South Carolina Medical Association to hold its annual meeting in 1950 at Myrtle Beach with the above counties as hosts.

(Signed) Norman O. Eaddy, M. D.

A. C. Bozard, M. D.

G. R. Wilder, M. D.

Sumter County Medical Society

(After reading the invitation Dr. Winter made a motion that the invitation be accepted.)

The Chair: You have heard the motion.

Dr. Brockman: I move we accept.

Dr. D. F. Adcock: We would like to invite the Association to come to Columbia. We can't beat a lot of things you have down here, but we are in the center of the state and we would like to have you.

The Chair: Do I get a second?

(Dr. N. B. Heyward seconds the invitation to go to Columbia)

I am going to ask those in favor of meeting in 1950 at Myrtle Beach to raise your hands. You will have to stand so the secretary can count you. (42 stood)

All in favor of going to Columbia for our 1950 Annual Session stand so the secretary can count you. (29 stood)

The Chair: Then we come back to Myrtle Beach for 1950. (Applause)

We will now have a report of the Tellers on the voting for Executive Committee for State Board of Health.

The following names were listed on the blackboard by the Nominations Committee, the seven receiving the highest vote to be declared elected:

W. A. Black	-----	Beaufort
L. D. Boone	-----	Aiken
R. L. Crawford	-----	Lancaster
R. B. Durham	-----	Columbia
Robt. W. Leonard	-----	Spartanburg
W. R. Mead	-----	Florence
W. L. Pressly	-----	Due West
J. A. Sasser	-----	Conway
C. J. Scurry	-----	Greenwood
Keitt H. Smith	-----	Greenville
W. R. Wallace	-----	Chester
J. I. Waring	-----	Charleston

Joe Cain, Chairman of Tellers made the following announcement:

Dr. J. I. Waring	63 votes
Dr. R. B. Durham	66 votes
Dr. W. L. Pressly	51 votes
Dr. Keitt H. Smith	49 votes
Dr. W. R. Mead	49 votes
Dr. L. D. Boone	48 votes
Dr. W. R. Wallace	44 votes
Dr. R. L. Crawford	26 votes
Dr. J. A. Sasser	25 votes
Dr. C. J. Scurry	25 votes
Dr. W. A. Black	20 votes
Dr. Robt. W. Leonard	14 votes

The Chair: The Seven men who were on the Executive Committee were re-elected.

Adjournment—(Upon Motion the House of Delegates adjourned)

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

EDITORIAL BOARD

J. I. Waring ----- Charleston
D. F. Adcock ----- Columbia
C. J. Scurry ----- Greenwood

R. M. Pollitzer ----- Greenville
W. J. Henry ----- Chester
W. R. Mead ----- Florence

J. J. Chandler ----- Sumter
O. Z. Culler ----- Orangeburg
G. D. Johnson ----- Spartanburg

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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JULY, 1949

MEDICAL CARE PLAN

Plans for the establishment of a South Carolina Medical Care Plan are progressing well. At a recent meeting of the Board of Directors, Dr. J. D. Guess of Greenville was elected President. Other officers are: Vice President, Mr. George Wilds, Hartsville; Secretary, Dr. George D. Johnson, Spartanburg; Treasurer, Mr. J. D. Ashmore (Pharmacist), Greenville. Application has already been made for junior membership in the (national) Associated Medical Care Plans. If this application is approved, the organization will be entitled to use the Blue Shield insignia and title. Further progress of the Plan will be announced to the members of our Association through this Journal.

REPORTING COMMUNICABLE DISEASES

Dr. Ben F. Wyman, State Health Officer, states that his office receives many requests for information concerning the general health conditions and incidence of reportable diseases in South Carolina from industries which contemplate establishing plants or branches in the State. His office is also asked for such health data by tourist and travel agencies, business associations, and agencies and branches of the government both within and without the State. Members of the South Carolina Medical Association frequently seek statistics concerning various reportable diseases. Good morbidity reporting furnishes these valuable and useful data.

The present method of reporting communicable diseases by numbers only has proven most unsatisfactory. During the past several years South Carolina has reported more cases of malaria and influenza than all the southeastern states combined. Such a record is most unenviable, and is certainly not enticing to prospective industry. The physicians of the State have, in far too many instances, failed to realize the value of the morbidity report cards, and have neglected to complete them and return them to the State Board of Health. Dr. Wyman says that, according to the records, approximately 1200 of these report cards are mailed each week to the physicians of the State, AND that only 300 to 350 cards are returned.

A new system of reporting has been adopted and will be placed into effect on or about July 1, 1949. The new system provides for the listing, by name of disease, name and address of patient, and patient's age, sex, and race on cards which will be mailed to each doctor on Tuesday of each week. (Special forms will be provided for cases of tuberculosis and venereal disease). Physicians are requested to complete their cards and place them in the mail, in penalty envelopes,

which will accompany the cards, at the close of business each Saturday. These envelopes should be mailed to the county health department in the county in which the physician maintains his office. Physicians are also requested to notify their county health departments, by telephone, of certain reportable diseases IN ADDITION to reporting them on the cards.

Every member of the Association is most urgently requested to cooperate fully in the use of the new reporting system, which is designed to provide useable information. The benefits to be derived from having and using reliable public health statistics will more than offset the few minutes time consumed in preparing the cards. All members of the medical association are urged to be 100% in their use of this new reporting system. *Help South Carolina progress.*

HONORS

We join with the rest of their friends in congratulating four of our members who have recently received particular honors.

Dr. W. L. (Buck) Pressly of Due West, was the recipient of the Honorary Degree of Doctor of Public Health, which was presented by the Medical College of the State of South Carolina.

Dr. W. R. Wallace of Chester, was awarded the gold "P" at the commencement exercises at Presbyterian College. The award is given annually to the alumnus who has made the greatest progress and achievement in his chosen profession. Dr. Wallace is a member of the board of trustees of the college.

Dr. J. L. Valley of Pickens, was honored by a "Dr. Valley Day" celebration recently in which citizens of Pickens County gathered to honor Dr. Valley who has been in practice in this community for forty-two years. Following a picnic supper Dr. Valley was presented with a new automobile, a bronze plaque, and a check for one thousand dollars. Several hundred of the six thousand babies whom Dr. Valley has delivered during his years of practice, were present for the occasion.

Dr. James R. Young of Anderson was recently presented with a beautiful bronze plaque by the American Cancer Society in token of his outstanding contributions to the control of cancer in 1948.

ATLANTIC CITY SESSIONS

(A Travelogue)

Several years ago I tried the experiment of giving an informal account of my trips to the American

Quinine

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All government restrictions on the use of quinine in general practice have been removed.

The clinical effectiveness of quinine, coupled with its almost complete absence of toxicity, strongly recommend it in the treatment of malaria.

You may again also prescribe quinine whenever its use is indicated, as in:

<i>minor surgery</i>	<i>influenza</i>
<i>hemorrhoids</i>	<i>myotonia</i>
<i>obstetrics</i>	<i>anemia (with iron)</i>
<i>varicose veins</i>	<i>hydrocele</i>
<i>trachoma</i>	

You may also prescribe quinidine whenever its use is indicated, as in:

<i>auricular fibrillation</i>	<i>ventricular tachycardia</i>
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Medical Association and other national conferences in place of formal reports—and some of the readers of the Journal actually read them. So here I try again.

We (Jack Meadors and I) left Florence at 11:30 Saturday morning, by plane. Spent two hours in Washington with my brother (who is an adviser on Far Eastern affairs in ECA) and his wife, and then flew on to Atlantic City in one of these big four-motor, 56 passenger affairs, arriving at 6:15 p. m. Flying certainly saves time and in this instance the fare was less than our return tickets (by train) are costing. Found our reservations at the Marlborough-Blenheim.

After eating a little supper we strolled down to the Traymore (the hotel headquarters for the convention) to get the lay of the land and to see who might be in the lobby. Ran into several friends: Underwood of Louisville (Secretary of Kentucky Association), Herbert Ramsey of Washington, D. C., Dwight Murray of California, and others. Spoke to Morris Fishbein and Joe Lawrence at the registration desk. Joe Lawrence is in charge of our A. M. A. office in Washington and was guest speaker at one of our meetings of the Pee Dee Society last fall.

Sunday morning we arose rather leisurely. Although the first part of the Grass Roots Conference was in session, my good Presbyterian training led me to the small Olivet Presbyterian Church. Sunday meetings of a medical nature appear to be inevitable at national and some state gatherings but I feel that things are going entirely too far when they interfere with attendance on Sunday morning services. There was a large inter-faith meeting at the convention hall (with a Protestant minister, Catholic Bishop and Jewish Rabbi speaking), but I had attended a similar gathering two years ago so chose the small church. As I strolled back down the Boardwalk after the services, I could not but wonder which would play the biggest part in the history of our nation in the century ahead—the Boardwalk or the Church.

After lunch, we went to the Conference of Presidents and other officers of state medical associations. This conference was established five years ago and serves as a forum for the expression of views. Outstanding individuals from various walks of life are invited to speak and all officers and leaders in state medical associations are invited to attend. (Two years ago, Senator Robert Taft was one of the main speakers.) Dr. Jim Howard of Bridgeport, Connecticut, President, presided.

The first address was given by William Alan Richardson, Editor of Medical Economics. Mr. Richardson has recently returned from a trip to England where he saw at first hand the conditions of medicine in that country. Here are some of the highlights of his remarks: The United States is financing one of the greatest experiments in socialism in history in English medicine today. The cost is staggering—around one and a half billion dollars (one-ninth of the annual income) per year. Estimates point toward an eventual cost of two and a half billion. Original estimates of cost were entirely wrong. In the field of ophthalmology the cost is 650% of the original estimate. As practiced, it is "quickie medicine". To see all his patients, a physician can allow only four minutes to each one. Some physicians see up to a hundred patients a day. One physician—by actual observation—got rid of eleven patients in eighteen minutes. Another M. D. actually saw 180 patients one day. The general practitioner's time is so tied up with trivial ailments that it is impossible to give any patient a thorough examination. The general practitioner gets \$3.40 per patient per year, regardless of the number of times

seen, but has some allowance for travel in rural areas. He averages from \$5,000 to \$6,000 net income per year (but the income tax on the amount runs around 40%). Medical schools are attracting an inferior quality student. Abuses in the present system are countless. Eighteen thousand out of twenty-one thousand physicians in England belong to the plan. A man is rated a specialist if he has an appointment in a hospital. There are no boards of certification. The paper work is overwhelming—at least three forms to be filled out on each patient. The one great advantage to the system is that medical care is prescribed and given without worrying about the cost—but "when the Marshall Plan aid is withdrawn, England will be in one hell of a hole".

George Lull, Secretary and General Manager, spoke next on the relationship between the American Medical Association and state medical associations. He stated emphatically that the medical profession was no longer on the defensive but was actually on the offensive. He stated that there was much to be done in our fight against socialized medicine. Our own members must know what the A. M. A. is and how it functions. We must educate the people.

Clarence Northcutt of Oklahoma, President-Elect of the Conference, discussed "The State Association at the Crossroad". He urged post-graduate training for its members, the need for a workable and working state organization, the necessity for cooperating with other than medical groups. He told of the successful conference held in Oklahoma for office nurses, secretaries, etc. He described the state association's grievance committee (composed of the last five past presidents) who passed on complaints of patients against doctors. In closing he begged further cultivation of the art of medicine.

Cecil Palmer of London, noted publisher, author, and journalist, spoke next. His address was so well received that he was given an ovation when he sat down. His speech will be published in an early issue of this Journal and it should be required reading for every citizen of this country. Here are some of the statements he made, as best I could get them in long-hand: I am opposed to socialized medicine on moral grounds, and those are the grounds upon which you doctors should oppose it. There is no compromise for the doctor, there are no terms of service under which he can agree to socialized medicine. He becomes the servant of the state and not the servant of his patient. Socialism will work only in heaven where they don't want it or in hell where they already have it. Lenin said, "If I can control the doctor, I can control the people". Socialized medicine in England has (1) revolutionized the status of doctors, making them servants of the state, and (2) destroyed the private and secret relationship between the doctor and his patient. A copy of records with diagnosis and treatment of patients must be made available to the local medical council made up of lay individuals. Socialized medicine is not working and cannot work. Economically, it will bankrupt England. Under socialized medicine doctors are merely glorified clerks and many are not even making a living. Doctors have little time to spend on their patients. They spend their time filling out forms. The great malady of England today is the philosophy that the way to strengthen the weak is to weaken the strong, and that one can get something for nothing. Paternalism is destroying the character of the English people. The two factors in England today which are growing and which might kill socialized medicine are the overwhelming cost, and the rising revolt of the women against the present system.

The last two addresses on the program dealt with

State Compulsory Disability Compensation Program—a subject of vital concern to a few states and one which may eventually become a concern to all of us.

The Conference of Presidents was closed with a reception and social hour at which all those in attendance were guests of E. R. Squibb & Sons.

Sunday evening was spent at a meeting of the Advisory Committee to the Cooperative Medical Advertising Bureau. The C. M. A. B. was established by the American Medical Association to handle national advertising for the state medical journals—and it is through this agency that our Journal secures most of its advertising. The Bureau is run by a director under the general supervision of an advisory committee (subject to the approval of the Board of Trustees) composed of five state journal editors, George Lull, Morris Fishbein, and Austin Smith. Only the director, his secretary, and we five editors were there and we spent a delightful evening together transacting business and chatting. (Incidentally, my travelling expenses to these meetings are paid by the C. M. A. B., which is a saving to our Association.)

The House of Delegates convened Monday morning and thanks to the Credentials Committee I was seated as a delegate although my official term does not begin until January 1, 1950.

For those who do not know how the House of Delegates operates, I would like to give a brief description. Each state is entitled to one delegate for each thousand members or fraction thereof. Each section of the A. M. A. Scientific Assembly (i. e. Orthopedics, Pediatrics, etc.) is also entitled to one delegate, as is each medical department of the armed forces, and the U. S. Public Health Service. The House is presided over by a speaker who is assisted by a vice speaker. The main work of the House is done by and in the reference committees. These are appointed by the speaker from the membership of the House. There are from eight to ten of them. Hugh Smith was appointed to the Reference Committee on Executive Sessions. Reports of the officers, the councils, and new resolutions are all referred to appropriate committees. The committees hold open meetings before which any delegate may appear to state his ideas and plead his cause. The committees then report back to the House of Delegates with recommendations to accept, reject, or modify the original report or resolution. This is the only way in which the House could handle the large amount of work which comes up before it, and is democratic. The Monday sessions were spent in hearing reports and resolutions. The one which evoked most comment was the one from the Board of Trustees relative to Morris Fishbein. As with other matters, it was referred to a reference committee for study.

Monday evening was spent at a banquet for the delegates given by the Board of Trustees. We four South Carolinians (Billy Weston, Sr., Buck Pressly, Hugh Smith, and myself) sat together. The entertainment was furnished by the Male Chorus of the Essex County (N. J.) Medical Society. One would have to go far to hear better choral music than that presented by these twenty-seven physicians. The speaker of the occasion was Lord Arthur Harden of England, prominent physician and former physician to the King—who gave an “off the record” discussion of medicine in England today. It is he who has recently organized the society for “Fellowship for Freedom in Medicine”.

Tuesday morning I spent at the Convention Hall, going through the commercial and scientific exhibits. One could spend many profitable hours in the latter. In the afternoon we went to the House of Delegates,

listening to and voting on reports from Reference Committees. An effort was made to do away with the General Practitioners Award—because of dissatisfaction with the method now being used for choosing the recipient. Some delegates felt that they were asked to choose one out of three names presented—and they had never seen any of the three. The effort was voted down, however, and I think some better method of selection will be worked out.

Tuesday night we were ready for a bit of relaxation so ten of us went up to Hackneys—the largest seafood restaurant in the world. It is capable of serving over three thousand at one time. To eat there is one of the musts on a trip to Atlantic City. In our party were Warren and Mrs. White, Lee Milford, J. R. Young, Buck Pressly, Hugh Smith, Jack Meadors, J. Morrison Hutcheson of Richmond, Warde Allen of Baltimore, and myself. Warde Allen is associated professor of medicine at Johns Hopkins. Earlier in the day we had met and in discussing mutual acquaintances found that his sister-in-law married the brother of my brother's wife. We still can't figure what kin we are to each other—but it gave us a good basis on which to start a friendship. He has already agreed to come down and speak before the annual meeting of the Pee Dee Medical Society this fall.

Wednesday, Hugh Smith and I were delighted to find that the House of Delegates did not have to meet and that we could be men of Science again. We let Jack Meadors do the honors by attending the special conference for executive secretaries and directors of public relations. This is known as the Conference of Executives. Jack was elected to the Board of Directors at this meeting. I spent most of the day in the sections on internal medicine and pediatrics. I was proud to see one South Carolinian, Billy Weston, Jr., on the program in the latter section where he discussed a paper on rheumatic fever. It is certainly interesting to run into South Carolina friends like this. Others I saw whom I have not mentioned so far were D. O. Winter, Frank Geiger, F. E. Zemp and Manly Hutchinson. Still others who were registered but whom I did not see were: P. M. Temple, I. W. Bell, Samuel M. Brown, Roy L. Cashwell, James Chandler, Elliott Finger, Jim Ouattlebaum, A. P. Rosenfeld, L. A. Schneider, Robert Taft, F. A. Bell, R. L. Crawford, E. F. Engel, A. E. Poliakov, George C. Rogers, R. H. Keyserling, Jack Parker, and Don Michie. (There is a daily printed bulletin listing the registrants and these names were secured from those.)

Wednesday evening I went to the Johns Hopkins Alumni Banquet, along with two other South Carolinians—Fred Kredel and Douglas Remsen. Ran into two of my classmates whom I had not seen since we were graduated in 1926, as well as some other friends.

Thursday morning was spent in the closing session of the House of Delegates. The final reports were brought in for consideration. The recommendation of the Board of Trustees with reference to Morris Fishbein was adopted without any discussion. Other matters were handled with dispatch. Elmer Henderson of Louisville was elected President-Elect, F. J. L. Blasingame of Wharton, Texas was elected to the Board of Trustees. Blasingame is a 42 year old surgeon and one of the leaders in medicine in his section of the country. It is interesting to note the younger men who are coming into the higher places in the organization of the A. M. A.

From an overall standpoint this was one of the most serious and forward looking sessions of the House of Delegates which I have observed. The members stuck on their job and did their work. There was no bitterness of debate and where differences of opinion arose it was usually the more forward looking opinion which

prevailed. The men seemed to realize the seriousness of the problem which confronts the medical profession today and wholeheartedly endorsed the efforts which the Board of Trustees and the firm of Whitaker and Baxter are making in our educational campaign. It was generally felt that excellent progress was being made but that we could ill afford to relinquish our efforts in the slightest.

Thursday evening we left Atlantic City, arriving in Florence Friday noon to find plenty of patients to be seen and plenty of work to be done.

BIRTHS

Dr. and Mrs. Robert B. Stith of Florence, announce the arrival of a daughter, Sheryll, on June 7.

Dr. and Mrs. Swift C. Black of Dillon are being congratulated upon the birth of a son, on May 31. He has been named Swift Curwood Black, Jr.

DEATHS

ISSAC DAVIS DURHAM

Dr. I. D. Durham died at his home in Lexington County on May 30.

A native of Orangeburg County, the son of Dr. William D. Durham, Dr. I. D. Durham attended the University of Georgia Medical School and was graduated in 1913. He then moved to Columbia and later to West Columbia where he engaged in general practice.

Dr. Durham was a family physician of the old school, loving and being loved by his many patients. As a friend said of him after his passing, "He was more than just a doctor to his patients, he was their counselor, their helper, and their friend. No man in his community will be more greatly missed."

Dr. Durham is survived by his mother, two sons, two brothers, and two sisters. One of his brothers is Dr. Robert B. Durham, recent president of the S. C. Medical Association.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

PRESIDENT

Mrs. J. L. Sanders, President of the Woman's Auxiliary to the S. C. Medical Association, was born in Athens, Georgia. She attended public schools and Lucy Cobb Institute there.

She is a charter member of the Woman's Auxiliary to the Greenville County Medical Society. Mrs. Sanders has served as president of the local auxiliary and has filled various other offices.

For the past twelve years she has been very active in the state auxiliary work, serving as convention chairman of membership, publicity, Hygeia, and other capacities. Since 1941 she has been State Treasurer.

Mrs. Sanders is also active in civic clubs. During her service as Publicity Chairman for one of Greenville's clubs, she won three consecutive years first and second prizes for editorial excellence in national press and publicity contests for Federated Clubs sponsored by the New York Herald Tribune.

Dr. Sanders is an Eye, Ear, and Throat Specialist of Greenville and is past president of the State Society of Ophthalmology and Oto-laryngology.

NOTE: Mrs. Sanders has three children: one daughter, Miriam, who is an accomplished musician in piano, organ, and violin. She is at present with WSB-TV in Atlanta, Ga. One son, Charles, is with the Mutual Life Insurance Co. of N. Y. and is located in Greenville, S. C. Another son, Dr. Harold L. Sanders, is an assistant resident physician at Emory University Hospital, Emory University, Ga.



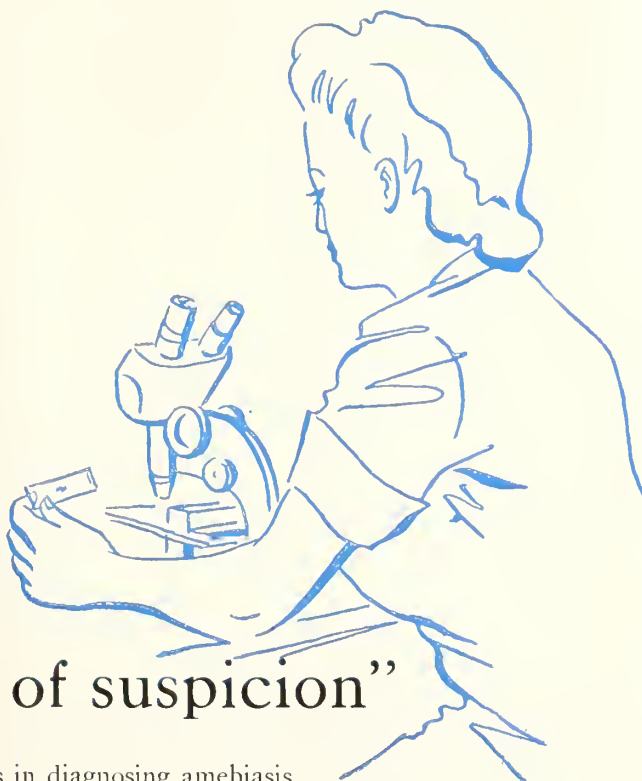
MRS. J. L. SANDERS

REPORT OF PRESIDENT

The Woman's Auxiliary to the South Carolina Medical Association held its 24th Annual Meeting May 17 and 18 at Myrtle Beach, South Carolina.

South Carolina is organized as nearly as practical to correspond with that of the National Organization. We have officers and committee chairmen correspond-

ing to those of the National Auxiliary and an Advisory Council of five doctors and the Director of Public Relations, and Counsel of the South Carolina Medical Association, as a member of the Council. A Fall Board Meeting was held in October to plan the year's work. Our organization is composed of twelve Auxiliaries, including 26 counties, comprising a membership of 548 and 7 Associate Members. We are sorry to report a loss of 4 members by death this past year.



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1. Warshawsky, H.; Nolan, D. E., and Abramson, W.: Hepatic Complications of Amebiasis, New England J. Med. 235:678 (Nov. 7) 1946.

2. Manson-Bahr, P.: Some Tropical Diseases in General Practice: "A Post-War Legacy," Glasgow M. J. 27:123 (May) 1946.

The program of activities for the year has been:

1. Much stress on Medical Legislation with informed speakers, radio and newspaper publicity, to give true facts to the public.
2. Public Relations and Child Health with extra effort on Diphtheria Immunization Programs, talks, and movies, have been held throughout the State. Health films have been purchased and shown.
3. Cancer Program—All members aided program, one County Auxiliary having the program in its entirety.
4. Membership—Teas for prospective and inactive members have created interest.
5. Nurse Recruitment—One group interested 200 girls with five minute talks by nurses in different lines of work. Panel discussions held which included parents.
6. A Nurse's Loan Fund which will be available before the Fall Term.
7. A Student Loan Fund for sons and daughters of doctors wishing to study medicine.
8. Cooperation in all projects and campaigns pertaining to health, and attending health councils and committees.
9. The "South Carolina Medical Auxiliary Bulletin" is a splendid instrument to contact all members. It is issued and paid for by the South Carolina Medical Association.
10. Biographies have been written of outstanding doctors in the State, and histories of doctors who have passed away.
11. One Auxiliary adopted a Maternity Ward in a hospital in France, donating supplies and money.
12. Doctors' Day, March 30th, is observed with much enthusiasm. All State Auxiliaries have been visited by the President. These occasions and contacts will always be remembered. They were splendid opportunities to learn at first hand the fine work being done by all Auxiliaries. All National projects have been carried forward.

The work of our organization has gone on steadily during 1948 and 1949. Each year the work becomes greater and the many problems facing the Medical Profession has increased our opportunities to be of service.

The experience of the past year has proven that the incoming President of this organization takes upon herself not only its duties but a debt of gratitude to those who have placed her there that cannot be easily replaced. Your President is always deeply conscious of this debt. To all members go heartfelt thanks, not

only for your inspiring cooperation, but also the privilege of serving you.

Respectfully submitted,
Elvy G. Temples, President,
Woman's Auxiliary to the South Carolina
Medical Association
(Mrs. P. M. Temples)

CONVENTION

The twenty-fourth annual convention of the Woman's Auxiliary to the South Carolina Medical Association was held in the Ocean Forest Hotel at Myrtle Beach, May 17 and 18 with the Auxiliary to the Pee Dee Medical Society as hostess. Mrs. P. M. Temples of Spartanburg, president, presided at the Executive Board meeting, the House of Delegates, the Program meeting, and the luncheon.

Honor guests at the convention were Mrs. Luther H. Kice of New York City, president of the Woman's Auxiliary to the American Medical Association, and Dr. W. L. Pressly of Due West, member of the advisory council and "General Practitioner of the Year". Both Mrs. Kice and Dr. Pressly spoke at the luncheon on May 18. Also introduced at the luncheon were Mrs. Leslie Lee of Kinston, N. C., president of the Woman's Auxiliary to the North Carolina Medical Association, and Dr. V. W. Brabham, Sr. of Orangeburg, chairman of the advisory council.

Mrs. J. L. Sanders of Greenville took office as president at the close of the Program meeting. Other officers elected were Mrs. A. F. Burnside of Columbia, president-elect; Mrs. J. L. Bundy of Rock Hill, first vice-president; Mrs. W. H. Powe of Greenville, second vice-president; Mrs. W. R. Mead of Florence, third vice-president; Mrs. R. B. Bultman of Sumter, fourth vice-president; Mrs. R. L. Sanders of Columbia, recording secretary; Mrs. Perry T. Bates of Greenville, corresponding secretary; Mrs. David Wilson of Greenville, treasurer, and Mrs. W. E. Simpson of Rock Hill, Historian.

Mrs. Sanders announced the following appointments of committee chairmen: Mrs. T. A. Pitts of Columbia, Chairman of Student Loan Fund with Mrs. V. W. Brabham, Sr. of Orangeburg, co-chairman and Mrs. M. Nachman of Greenville, Treasurer; Mrs. Roderick McDonald of Rick Hill, Jane Todd Crawford Memorial; Mrs. Furman Wallace of Spartanburg, Public Relations; Mrs. C. P. Corn of Greenville, Hygeia; Mrs. J. A. Seigling of Charleston, Membership; Mrs. Manly E. Hutchinson of Columbia, Legislative; Mrs. M. J. Boggs of Abbeville, Bulletin; Mrs. H. L. Timmons of Columbia, Parliamentarian; Mrs. R. D. Hill of Pacolet, Nurse Recruitment, and Mrs. Kirby D. Shealy of Columbia, Publicity with Mrs. David F. Adcock of Columbia, co-chairman.

CORRESPONDENCE

18 May, 1949

Dr. Julian P. Price, Secretary
South Carolina Medical Association
105 West Cheves Street
Florence, South Carolina

Dear Dr. Price:

The Department of the Army is urgently in need of Public Health Officers to serve in a civilian capacity with the occupation forces in Japan. These positions, which involve supervision of Japanese prefecture (state) health departments in all phases of preventive medicine and medical care programs, offer an excellent opportunity for broad experience in public health. We will greatly appreciate your assistance in locating qualified and interested candidates for this program.

Minimum acceptable qualification requirements are a degree in medicine plus one year internship. Experience in public health is desirable but is not mandatory.

The salary for these positions is \$6235.20 per an-

num plus 10% post differential with quarters provided at no cost to the employee. Individuals selected for appointment must agree to remain a minimum of two years. Transportation is furnished to and from Japan. Dependents may join the employee in approximately 6 to 8 months after his arrival in the command.

It will be appreciated if you will publicize this information and advise interested applicants to make formal application by submitting Civil Service Commission Standard Form 57 to this office. Forms may be obtained from any Class A Post Office.

The necessity for immediate recruitment of qualified and suitable personnel cannot be overemphasized. Your assistance in this vital program will be most beneficial to the Department of the Army.

Sincerely yours,
CHARLES C. FURMAN
Chief, Recruitment Section
Overseas Affairs Branch
Civilian Personnel Division

Call 41639 . . .

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The Journal of the South Carolina Medical Association

VOLUME XLV

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NUMBER 8

Carcinoma Of The Endometrium*

Development of Treatment and Results

From the Free Hospital for Women

Brookline, Massachusetts

EDWARD B. SHEEHAN, M. D.

AND ARTHUR W. TUCKER, M. D.

Free Hospital for Women

Dr. Shields Warren, in a recent article on the cancer problem, wrote: "To treat effectively a disease of unknown etiology, of inevitably fatal course if untreated; a disease for which no specific therapy exists, might well be considered hopeless . . . However, progress in diagnosis and in treatment of certain types of cancer has been and is being made." In reading this the pessimist will be apt to stop after the first statement; while the optimist will be inclined to remember only the second. Following the ancient adage that "in medio stat virtus," I shall attempt in treating of my subject to be realistic,—a pessimistic optimist; and while making no attempt to minimize the seriousness of this problem of endometrial cancer, I shall endeavor to show that the dark cloud really does have a silver lining; that in diagnosis and in treatment real definite progress has been and is being made.

The problem is serious. In this country, out of every 1000 women who reach the age of forty, from 30-35 will develop carcinoma of the uterus; and more than 16,000 women die annually from this disease. Excepting carcinoma of the cervix, the most frequent malignant tumor of the female genital organs is endometrial or fundal carcinoma. Between the ages of 45 and 55, cancer of the endometrium occurs in the ratio of 1 to 4 or 5 of cervical cancer. The relative frequency of fundal cancer, however, increases with age until in the age span of 70 to 75, carcinoma of the cervix and of the fundus occur with equal frequency. A majority of patients with carcinoma of the fundus are between 50 and 60 years of age. The youngest patient with this type of carcinoma seen at the Free Hospital for Women in Brookline was twenty-three, the oldest was eighty-five.

The results of the most recent research on the causes of cancer are interesting and indicative rather

(Presented by Dr. Sheehan at Annual Session S. C. M. A., May 19, 1949.)

*This study was aided by a grant from The American Cancer Society (Mass. Division).

than conclusive. Thus the possibility of a causal relationship between continued estrogen stimulation and carcinoma of the endometrium is being taken very seriously. Clinically it has been observed that women with carcinoma of the endometrium frequently have a history suggesting prolonged estrogen activity. Thus sixty percent of women with endometrial cancer continue to menstruate after the age of 50, whereas only fifteen percent of women without this disease menstruate beyond this age. Again elderly women with carcinoma of the endometrium frequently have surprisingly well preserved vaginal mucous membranes while carcinoma of the endometrium is seldom found in women with marked genital atrophy or atrophic vaginitis.

This possibility of a causal relationship would seem to be supported by the fact that carcinoma of the endometrium has been found after administration of estrogens. In 1946, Drs. Fremont-Smith and Meigs reported a case of carcinoma of the endometrium which followed prolonged estrogen administration. Gusberg, from the Sloane Hospital, has reported five cases in which he felt that carcinoma of the endometrium actually resulted from prolonged estrogen therapy, and three cases in which he felt that the development of carcinoma had been accelerated by the use of estrogens. These cases are difficult to evaluate and the role of estrogen per se may be a minor one. Experimentation has shown that estrogen in prolonged unphysiological doses is carcinogenic in susceptible animals, so that quite conceivably, in susceptible humans, prolonged doses of estrogen may tip the balance of unknown biological factors in such manner that endometrial malignancy will result. Moreover, a number of cases have been found in association with granulosa cell tumors of the ovary, the reported instances being from 10 to 20%. Since granulosa cell tumor is estrogen producing, this would appear to be more than coincidence and would seem to substantiate the opinion that continued estrogen stimulation may carry endometrial hyperplasia on to cancer.

On the other hand, considering the sensitivity of the endometrium to the hormone at any age, and the large number of women who are receiving estrogenic therapy for various reasons, it would appear that if estrogenic stimulation were actually the cause, then more cases of endometrial carcinoma, following such therapy, should have been reported in current literature.

As I have stated in the beginning, this research is indicative rather than conclusive but personally, I consider the indication sufficient to constitute a warning; that until more is known concerning the role of hormones in cancer of the endometrium it is advisable to use these agents with the greatest of care even when the indication for treatment would seem to be well defined.

For the same reason the following deserves mention and consideration. Pelvic irradiation is frequently used in treatment of benign pelvic conditions. It is given to remedy a present condition, but often with the unexpressed hope that such irradiation may serve as a prophylactic measure against corpus cancer. Recently, the suspicion—if it is not a formulated opinion—is growing that radiant energy may actually stimulate cancer formation in the uterus. Thus twenty-one out of 270 patients treated for malignant tumors of uterine fundus had a history of previous pelvic irradiation for benign conditions. From wider figures it is estimated that the incidence of carcinoma in a series of patients previously treated by radiation for benign pelvic conditions is 3.4 times as large as the number expected in the same age distribution of the general population. 8% of patients in a series of fundal carcinoma gave a history of previous radiotherapeutic menopause, as compared with only 0.3% of patients with cervical carcinoma. In other words, previous radiation was found to be 27 times as common among patients with fundal as with cervical carcinoma. Can we conclude from this, that radiant energy bears some causal relationship to the later development of fundal carcinoma? As yet we cannot do so with anything like certainty. Up to the present this disparity has usually been attributed to the underlying condition for which radiation was used. At the same time, this should be noted. As we have said, it is quite possible that the estrogenic factor may be causally important in endometrial carcinoma. X-ray and radium in menopause-inducing dosage is not always sufficient to cause complete cessation of ovarian function, and subsequent estrogenic activity may follow. In mice the ovary which has been exposed to X-ray undergoes a phase of regeneration in which proliferation of germinal epithelium and granulosa cell tumors often results. Carcinoma of the uterus has been caused in rabbits by exposing them to X-ray. All this suggests at least the possibility of a carcinogenic effect of radiant energy on human uterine fundus; and because of this possibility, a follow up is being done at the Free Hospital for Women on all

patients previously treated with radium or X-ray for benign conditions. Once again, then, this study is at present merely indicative; but at the same time it is sufficient to constitute a warning against indiscriminate or even routine usage of radium and X-ray for *benign* conditions of the uterus.

In 1941, Dr. George V. S. Smith of the Free Hospital, in studying sections of ovaries from cases of carcinoma of the endometrium, found ovarian stromal hyperplasia in 87% of 180 post-menopausal cases. In a later study, Dr. Arthur Hertig, our pathologist, found that the appearance of stromal hyperplasia after the age of 50, was seen with greatest frequency in cases with either continued endometrial activity or outright malignancy. On the basis of these observations, Drs. Smith and Hertig undertook a study:

1. To learn the stromal changes of the ovary from infancy to old age.
2. To study the ovaries in carcinoma of the endometrium.
3. To compare these with a control group.

The ovaries in 331 cases of endometrial carcinoma were studied. Ovaries of 307 cases in the same age group, which had no appreciable clinical gynecological disease, together with sections of ovaries from newborn infants and from adolescents, were studied and used as a control.

As a result of this study, it was concluded that the ovarian stroma is capable of differentiating into cells of the granulosa, theca interna, corpus luteum and corpus albicans. The process normally follows an orderly sequence, possibly regulated by the ovum. In senility, this differentiation passes through the normal sequences, but in a disorderly manner, leading to stromal hyperplasia, cortical granuloma formation and granulosa and theca cell tumors. Stromal hyperplasia was significantly more frequent in cases of endometrial carcinoma, than in the control group and persisted into advanced old age. The incidence of thecoma, an estrogenic tumor derived from the stroma, was nine times as great in the carcinoma group as in the controls. The opposite ovary invariably showed stromal hyperplasia, but not necessarily of a high degree of activity.

Study of the endometrium in these cases showed a significant, but far from constant association, of endometrial proliferation with carcinoma. Endometrial proliferation is interpreted as reflecting secretion of estrogen by the ovaries. Cancer may occur many years after the menopause in patients in whom there has been no known intervening exposure to estrogen. We have had at the Free Hospital, three cases of carcinoma of the endometrium following bilateral oophorectomy 15, 17 and 30 years previously. Although some estrogen is excreted after removal of the ovaries, and assumed to be of adrenal origin, it has

not been reported as sufficient to cause endometrial proliferation.

This study confirms from another angle the warning that until more is known concerning the role of hormones in cancer of the endometrium, it is advisable to use these agents with great care, even when the indication for treatment seems to be well defined. Although the weakness of *histologic* grading of malignant tumors is particularly evident in the study of carcinoma of the uterus, several definite *clinical* entities may be recognized:

1. The majority of malignancies arising in the endometrium consist of a fairly mature adenocarcinoma extending into the myometrium, but tending to reproduce a definitely glandular type. Although this type tends to metastasize slowly, it is a definitely progressive malignant disease.
2. Anaplastic adenocarcinoma is highly cellular with varying amounts of massing of undifferentiated cells which metastasize earlier.
3. Adenoacanthoma is a rarer type having islands of proliferating squamous cells within adenocarcinomatous areas.

The typing of simple adenocarcinoma and adenocarcinoma with varying amounts of undifferentiated cells, is only roughly accurate, and depends in great measure on the number of sections taken from different parts of the same tumor. Some sections from a tumor may appear adenomatous, and others, from the same tumor, may show masses of undifferentiated cells or even areas of squamous carcinoma. More sections from the same tumor might change the classification. For this reason it is difficult, if not impossible, to *correlate* with any accuracy the *grade* of malignancy either with duration of symptoms, with gross extent of disease, or with length of survival. Neither duration of symptoms nor the microscopic grade of malignancy bears any constant relationship to the extent of the disease at the time of treatment, or to the length of survival. Some cases with low microscopic malignancy have metastases without advanced local growth. Recurrences often look more active than the primary neoplasm. In some cases with cancers of relatively high activity microscopically, growth of recurrence was slow, and death has occurred as late as twelve years, eight months after operation.

Carcinoma of the fundus usually extends slowly as compared to carcinoma of the cervix. Lymphatic drainage from the corpus extends within the superior portions of the broad ligament along the course of the ovarian vessels and round ligament. When adenocarcinoma involving both the uterine wall and the ovaries is found, the specimen should be carefully studied in order to determine whether the carcinoma is primary in the ovary or primary in the endometrium; or whether it is really two separate cancers. The ovaries may be involved early in carcinoma of the endometrium; but such involvement by metastatic

carcinoma does not imply as poor a prognosis as cancer which is primary in the ovary and has extended to the uterus. In our series, eight cases were found of primary carcinoma of the ovary with distinct primary carcinoma of the endometrium as well.

A diagnosis of early carcinoma of the endometrium is extremely difficult. Unlike carcinoma of the cervix, little can be found on examination to arouse one's suspicions or even to confirm a diagnosis. Frequently, however, we can secure suggestive information from a complete history. Thus a history of infertility, of delayed menopause and of dysfunctional flowing is frequently found in women who develop carcinoma of the endometrium. A history of treatment for uterine fibroids may be indicative. A patient with a history of menorrhagia during the climacteric is 4 times more apt to have carcinoma of the endometrium than one who during that time has had no increased bleeding. As previously stated it is quite within the realm of possibility that a history of irradiation for benign conditions may be indicative.

An added difficulty in early diagnosis is the fact that the vaginal smear is of less value in the diagnosis of early carcinoma of the endometrium than it is in carcinoma of the cervix. At the Massachusetts General Hospital, vaginal smears from 5,621 women were studied. In 113 cases of endometrial carcinoma, 83 were diagnosed by smear, an error of 26.5%. In 354 cases of carcinoma of the cervix, the diagnosis was made by smear in 317, an error of 10.5%. There were 69 cases in which a positive diagnosis by smear was not confirmed by pathological examination, a false positive of 1.3%. In cases of proved cancer, the smear failed to detect malignant disease in about 20% of endometrial and 10% of cervical carcinoma. The initial vaginal smear missed one in ten of carcinoma of the cervix and two in ten of endometrial carcinoma.

At the Frec Hospital for Women, Dr. Hertig and others studied 1045 cases both by vaginal smear and by tissue examination. In forty cases of carcinoma of the cervix, there were 39 positive smears; an error of only 2.5%. In 18 malignancies of endometrium, there were 15 positive smears, an error of 16.6%. In seven cases of definite carcinoma in situ of the endometrium, there was a positive smear in only one; and in eight cases with a tissue diagnosis of probable or possible carcinoma in situ, there were no positive smears. This indicates the difficulty of vaginal smear diagnosis in this type of lesion, which is less apt to cast off cells into the uterine cavity. Thus the smear is of least value in the earliest type of lesion where the diagnosis is of most importance.

It is to be noted that a negative smear does *not* exclude the possibility of carcinoma. On the other hand a positive smear does *not* indicate operation for the very simple reason that an occasional false positive is inevitable. The study and use of the vaginal smear has had one very important extrinsic result; it has enlarged our understanding of symptoms and signs which should be recognized as possible evidence

of early carcinoma. As a result of a study of 2876 vaginal smears, conducted by the Massachusetts Department of Public Health, it was concluded "The vaginal smear technique may lower cancer mortality more because it has made a large number of physicians aware how really *insignificant* are the signs and symptoms which may be associated with early carcinoma than because of the early cases it discloses."

Very briefly and very simply irregular bleeding still remains the most common symptom of uterine cancer; and it is, for all practical purposes, the only real symptom of cancer in the fundus. Contrasted with carcinoma of the cervix, in which the lesion may be palpable or visible, carcinoma of the endometrium presents the added problem of concealed bleeding. Moreover, the cervix in most cases is either atrophic, intact or may show only minor endocervicitis or erosion. The uterus may not be appreciably enlarged, the pelvis may be soft. Therefore, since 75 to 85% of patients with fundal carcinoma have passed the menopause, post-menopausal bleeding of any kind whatsoever, makes a diagnostic curettage mandatory, no matter what the clinical findings on examination may be. In post-menopausal patients carcinoma of the fundus will never be overlooked, if in every case of post-menopausal bleeding the probability of its presence is kept in mind and a diagnostic curettage resorted to immediately.

In patients who have not passed the menopause, an early diagnosis is still more difficult; and it is most difficult, and the danger of missing such early diagnosis is greatest, in the case of patients between the ages of forty and fifty in whom the periodicity of menstruation has not ceased. The reason for this is clear. The early symptoms of carcinoma of the fundus are minimal, consisting of painless bleeding either in the form of slight menorrhagia, metrorrhagia or spotting. Such bleeding may actually be due to other causes. Thus, during the child bearing age abnormal flowing may be considered to be—and frequently is—some form of dysfunctional bleeding. Later on, slight bleeding with a negative pelvic examination may be interpreted to be—and frequently is—a manifestation of the menopause. Again natural and synthetic estrogens used for the relief of the vaso-motor symptoms incident to the menopause frequently produce bleeding. All this tends to confuse and render the diagnosis difficult. Moreover, the finding on examination of a fibromyoma does not exclude endometrial carcinoma. One is frequently associated with the other; and in our series of fundal carcinoma thirty and six tenths percent had fibroid tumors at time of treatment for carcinoma. Since all this is true, there is only one safe procedure; the presence or absence of carcinoma *must* be determined by a diagnostic curettage. If careful examination under anesthesia with curettage and cervical biopsies fails to reveal the cause of flowing, careful, persistent follow-up is absolutely essential. It is not enough to say that in every case a

biopsy must be obtained. One negative biopsy is *never* enough if the symptoms persist; and repeat biopsies must be done until or unless some benign cause of recurrent bleeding is absolutely demonstrated.

In concluding this section, let me insist. If and when every single case of post-menopausal vaginal bleeding of any kind; if and when every single case of *abnormal* bleeding in patients of any age, is taken very seriously and is considered to be due to cancer until a definite diagnosis is made, then and then only will patients who actually have cancer of the fundus obtain the early diagnosis and receive the early treatment which is at present the one efficacious means of cure which we possess. This must be our bulwark of defense against this form of carcinoma until that bright day dawns when a specific therapy for general cancer is found.

Between May 1, 1903 and December 31st, 1940, 443 cases of carcinoma of the endometrium were treated at the Free Hospital for Women in Brookline. Prior to November 1916 when radium was first used in the hospital, the treatment was hysterectomy, either complete or supravaginal, with removal of tubes and ovaries. When radium was first used as treatment for uterine cancer, it was given as the sole treatment, and was used only in poor operative risks or in cases which were too far advanced for surgery. The results of treatment by radium alone in cases of carcinoma of the cervix were good; in fact the results were so good that the use of radium largely supplanted surgery in the treatment of this type of carcinoma. On the other hand, the results of treatment by radiation alone in carcinoma of the fundus were poor and did not compare at all with the results obtained in the treatment of carcinoma of the cervix, so that radiation came to be used in carcinoma of the fundus mainly for purposes of local palliation. Although the survival rate was poor in the treatment with radium alone, still there were patients who had been given radium as a palliative measure who survived five or more years. Moreover some of these patients who were not good operative risks and who were given radium, actually improved to such an extent under medical supervision that operation was undertaken five to fourteen months later. In fifty percent of these cases active cancer was found in the removed specimens.

Since many patients who had been treated by surgery alone developed recurrences at the top of the vagina as well as pelvic and more distant metastases in a relatively short time, it was natural to turn to radiation with the hope of preventing or at least postponing recurrence; and thus we came to use radium, not only as a treatment to replace surgery in the case of patients not considered eligible for surgery; but also as a prophylactic before and as a supplementary measure after surgery.

At this time there were no definite indications to be followed in the selection of patients for pre-operative radiation. If the uterus was enlarged by tumor, it

was thought that shrinkage and improved drainage resulting from radiation would be of advantage. Pre-operative radiation also seemed indicated where there was cervical or vaginal extension. It is to be noted that in all these cases, pre-operative radiation was not used in the belief that its application would destroy all the cancer, but in the belief that it would render subsequent surgery safer by reducing infection and lessening the possibility of disseminating viable cancer during operation; and also that it would reduce the incidence of recurrence in the vaginal vault scar.

When used pre-operatively the radium capsules were placed in tandem in a tube of 1.0 mm. brass and 1.0 mm. lead from the top of the uterine cavity to or through the external os for a total dosage of 2400 to 3600 mg. hours. Four to seven weeks later, hysterectomy was performed.

Post-operative radium was used especially in patients who had not received radium pre-operatively. A cylindrical bomb of 1.0 mm. brass and 2 mm. lead was applied transversely across the vaginal vault from two to ten weeks post-operatively. The majority of doses was 2000 to 2400 mg. hours. Post-operative X-ray treatment when used was started within eight weeks of operation.

Since 1935 combined X-ray and radium treatment before and/or after operation has been used as practically routine, with, however, no set plan as to the sequence of surgery and radiation. Radium dosage has been increased to at least 3000 mg. hours pre-operatively and to at least 2400 mg. hours when used post-operatively. Patients who are not operated upon, receive two applications of radium, two to eight weeks apart, totalling 4800 to 6000 mg. hours. Since 1937 X-ray treatment has been given in a single consecutive series, and an attempt is made to complete all treatment in eight weeks.

Over the years, under certain conditions, supra-vaginal instead of complete hysterectomy has been used. Obesity, cardiovascular disease, fixation of the lower uterus and cervix, deep in the pelvis, hopeless extension and metastases—these, alone or combined, were the factors which determined the necessity for the incomplete procedure.

Complete hysterectomy with removal of adnexa and at least a small vaginal cuff was from the beginning the basis of treatment for carcinoma of the endometrium; and any plan of treatment not including complete hysterectomy with removal of adnexa was and must still be considered a compromise. The operation should include pre-operative closure of the cervical canal to avoid possible extrusion of viable tumor during the operation. For the same reason, the tubes are ligated as soon as the abdomen is opened. Clamps are applied to the broad ligaments and used for necessary traction. No instruments should be applied to the fundus and manipulation of the uterus should be reduced to a minimum. A wider excision of the broad and infundibulo-pelvic ligaments is done

than in hysterectomies for benign conditions. Clamping of the entire parametrium down to the vaginal vault as early as possible may help to prevent the spread of the disease through the uterine veins and lymphatics during the early stage of the operation.

Studying these various stages in the development of treatment, the results do not engender complacency or self satisfaction; nor do they warrant any feeling that we can rest on our laurels; but they do give indication of substantial and solid progress and amply justify hope of further success in the years to come.

There is a common saying that a set of figures may be so manipulated as to tell any story; that even though figures themselves do not lie, they can be made to do so. In working out statistics and in figuring percentages, we have been very realistic and have made no attempt whatsoever to brighten the picture. In fact, we have tended to stress the dark side. Cases of carcinoma in situ, or pre-invasive carcinoma, are not included in the study as in these cases we expect 100% cure, and there is not universal agreement that the condition is cancer. The complete picture is given; and in every series, all patients have been included, even those who because of the hopelessly advanced stage of the disease were not treated. Cases which were "untraceable" were presumed, for the purpose of statistics, to have died of cancer.

Between 1903 and 1925, 118 patients with carcinoma of the endometrium were seen. Three of these were untreated because of the advanced stage of the disease. Fifteen were considered inoperable and were treated with radium alone. Of the fifteen, three were alive at five years, one at ten and none at fifteen years. Thirty-seven patients were treated by supra-vaginal hysterectomy with one post-operative death, and with twelve deaths and two untraceable at five years, thus giving a five year survival rate of 59.5%. 63 complete hysterectomies were done, with seven post-operative deaths and a five year survival rate of 61.2%. Compared with the survival rate of the supra-vaginal group, the percent of the survivors in the complete hysterectomy group increased with time until at fifteen years, the percent of survivors was 30.1% compared with an 18.9% survival in the supra-vaginal group. In this total series of 118, 54.2% were alive at five years; 38.9% at ten years; 22% at fifteen years; and 11.7% were alive twenty years after treatment.

Radiation was first used in conjunction with surgery between the years 1926 and 1930. During this period a total of 88 patients were treated; nine by radiation alone, 23 by a combination of surgery and radiation and fifty-five of the 88 were treated by surgery alone; twelve by supra-vaginal and 43 by complete hysterectomy. In this series there were four post-operative deaths; the survival at five years was 55.6%, at ten years 45.5%, and at fifteen years 29.6%. Thus the over-all results were considerably better than in the previous series. There was, however,

CARCINOMA OF THE ENDOMETRIUM
Treatment and results, Consecutive cases, 1903-1940, inclusive, by 5 year follow-ups

I. 1903-1925	No. of cases	P. O. Deaths	5 year status			10 year status			15 year status			20 year status		
			Untr.	Dead	Alive	Untr.	Dead	Alive	Untr.	Dead	Alive	Untr.	Dead	Alive
Untreated	3	1	0	2										
S. V. H.	37	1	2	12	22 (59.5%)	3	6	15 (40.5%)	4	6	7 (18.9%)	2	1	6 (16.2)
C. H.	63	7 (11.1%)	0	17	39 (61.9%)	3	6	30 (47.6%)	5	6	19 (30.1%)	5	6	8 (12.7)
Radium	15	0	1	11	3 (20.0%)	0	1	1 (6.7%)	0	1	0	0	0	0
TOTALS:	118	9	3	42	64	6	13	46	9	13	26	7	7	14
%:	7.6%		2.5%	35.6%	54.2%			38.9%			22.0%			(11.7)
II. 1926-1930														
Untreated	1			1										
S. V. H.	12	1	0	5	6 (50.0%)	0	0	6 (50.0%)	0	2	4 (33.3%)			
C. H.	43	2	2	11	28 (65.2%)	1	3	25 (58.2%)	5	4	16 (37.2%)			
Radium	9	0	0	5	4 (44.4%)	0	2	2 (22.2%)	1	1	0			
S. V. H. with rad c/s xray	11	0	0	7	4 (36.3%)	0	2	2 (18.3%)	0	0	2 (18.3%)			
C. H. with rad c/s xray	12	1	0	4	7 (58.3%)	0	2	5 (41.6%)	1	0	4 (33.3%)			
TOTALS:	88	4	2	33	49	1	9	40	7	7	26			
%:	4.5%		2.3%	37.5%	55.6%			45.5%			29.6%			
III. 1931-1935														
Untreated	1	1												
S. V. H.	3	0	0	2	1 (33.3%)	0	1	0 (0%)						
C. H.	13	2	0	4	7 (53.8%)	1	0	6 (46.2%)						
Rad without xray	20	3	1	10	6 (30.0%)	0	3	3 (15.0%)						
S. V. H. with rad & or xray	12	0	0	3	9 (75.0%)	1	3	5 (41.7%)						
C. H. with rad & or xray	68	1	0	24	43 (63.2%)	4	8	32 (47.1%)						
TOTALS:	117	7	1	43	66	6	15	46						
%:	5.9%		.85%	36.7%	56.4%			39.3%						
IV. 1936-1940	120	1	4	37	78									
		(.83%)	(3.3%)	(30.8%)	(65%)									
CUMULATIVE														
TOTAL	No. of cases		5 year status			10 year status			15 year status			20 year status		
SURVIVALS:	443		257			132			206			118		
			58.0%			40.8%			25.2%			11.7%		

TREATMENT AND RESULTS, CONSECUTIVE CASES, 1936-1940,
(inclusive, by 5 year follow-ups) (continued)

V. 1936-1940	No. of cases	P. O. deaths	5 year status		Untreated	Status at 5 years	
			Dead	Alive		Dead recur.	Alive and well
Untreated	2	0	0	2	0		
S. V. H.	3	0	0	1	2 (66.6%)		
C. H.	12	1	2	2	8 (66.6%)		
Vag. Hyst.	2		1	1	1 (50.0%)		
Radium &/or x-ray tr.	23	0	11	11	11 (47.8%)		
S. V. H. with rad &/or x-ray	3	0	2	1	1 (33.3%)		
C. H. with rad &/or x-ray	75	0	18	55	55 (73.4%)		
TOTALS:	120	1 0.83%	37 30.8%	78 65.0%			

TREATMENT AND RESULTS, CONSECUTIVE CASES 1936-1940 BREAKDOWN BY TYPE OF TREATMENT							
GROUP I.	Number of cases	Op. deaths	Untreated	Dead recur.	Lead int. dis.	Status at 5 years	
						Alive recur.	Alive and well
A. X-ray, radium, C. H.	1						1 (100%)
B. Radium, X-ray, C. H.	20			2	3	2	13 (65%)
C. C. H., radium, X-ray	16			3		2	11 (68.7%)
D. C. H., X-ray, radium	6			2			4 (66.6%)
E. Radium, C. H., X-ray	8		1				7 (87.5%)
TOTALS GROUP I.	51	0	1	7	3	4	36 (70.6%)
GROUP II.							
A. X-ray, C. H.	1						1 (100%)
B. Radium, C. H.	4		2	2			2 (50%)
C. C. H. X-ray	14		1	2	1		10 (71.4%)
D. C. H. radium	5		3				2 (40%)
TOTALS GROUP II.	24	0	1	7	1		15 (62.5%)
GROUP III.							
A. S. V. H., X-ray c/s ra.	2	0	0	1	0	0	1 (50%)
B. X-ray c/s ra., S. V. H.	1	0	0	1	0	0	0%
TOTALS GROUP III.	3	0	0	2	0	0	1 (33.3%)
GROUP IV. (no radiation)							
A. C. H.	12	1	1	2	0	0	8 (66.6%)
B. S. V. H.	3	0	0	0	1	0	2 (66.6%)
C. V. H.	2	0	0	1	0	0	1 (50%)
D. Untreated	2	0	0	2	0	0	0%
TOTALS GROUP IV.	19	1	1	5	1	0	11 (57.9%)
GROUP V.							
X-ray, Radium	23	0	1	8	3	1	10 (43.5%)
TOTALS—GROUPS I-V:	120	1 (83%)	4 (3.3%)	29 (24.2%)	8 (6.6%)	5 (4.2%)	73 (60.8%)
/C. H. (early cases)	12						8 (66.6%)
/C. H. plus Radiation	75						51 (68.0%)
/Radiation alone	23						10 (43.5%)
GRAND TOTAL: 1903-1940 incl.:	443						257 (58.0%)

one result which at first glance would appear contrary to expectation. The highest percentage of five, ten, and fifteen year survivals in this series was the group treated by complete hysterectomy without radiation. Thus the five year survival rate for complete hysterectomy alone, was 65.2% while that for hysterectomy plus radiation was only 58.3%.

However, the selection of patients for the various types of treatment might possibly explain the discrepancy in results. During this period complete hysterectomy alone was considered the ordinary procedure and was used in all cases in which the disease was not thought to have extended beyond the uterus. The use of radium alone was restricted to those patients who were considered inoperable; the supra-vaginal hysterectomies were performed only where necessary because of the extent of the disease or because of complications; and finally, the combined radium therapy with surgery was used only in the intermediate group. Thus the survival expectation of this group would naturally not be as good as that of the group in which surgery alone was used. This conclusion might be confirmed by a report from the Barnes Hospital and the Barnard Free Skin and Cancer Hospital of St. Louis, where 93 patients with cancer of the endometrium were treated. Of the entire group 18 were treated by hysterectomy alone, 32 with combined radiation and hysterectomy; with a higher survival rate for five years in the former than in the latter. Drs. Stanbro and Nolan who conducted the study state that the unusually high survival rate from hysterectomy alone, was attributable to selection of favorable clinical material, during this period of transition to routine pre-operative radiation.

In the next five years from 1931-1935 there were 117 consecutive cases of endometrial carcinoma. During these years, fewer cases were treated by surgery alone; and at the same time there was an increase both in number and in percentage of those treated by radiation without surgery; 17 by surgery alone and 20 by radiation alone. Now for the first time in our total series, the largest group, 68 of the 117 patients received combined treatment of complete hysterectomy with radium or X-ray or both. Twelve supra-vaginal hysterectomies also received supplementary radiation, making a total of 80 patients who were treated by surgery plus radiation.

Once again the results statistically were disappointing. The survival rate, 56.4% of the total 117, was no better than in the two previous groups. A more detailed break-down brought some consolation. The twenty patients who were treated by radiation alone had been deemed unsuitable for surgery and their five year survival rate was only 30%. This would, of course, lower considerably the over-all percentage. Nevertheless, the five year survival rate of the 68 who were treated by complete hysterectomy plus radiation was only 63.2%, as compared with a five year survival of 65.2% for the previous group which had been treated by complete hysterectomy without

radiation. During this period there was no change of operative technique to account for this lack of improvement. It was noted, however, that 32% of this group had either extension of the disease locally, distant metastases or another primary malignant tumor at the time of treatment, as compared with only 22% in the preceding group and 17% in the earliest group. Hence we could find some encouragement by concluding that in all probability the extra manipulation and the delay incident to pre-operative radiation did not affect the results adversely, but rather, that the survival rate in this group would have been still worse if radiation had not been used.

Even though the survival rate was not improved in this first group in which, for a majority of cases, combined surgery and radiation was used, nevertheless this procedure was continued, and now we feel certain that the results have justified our doing so.

In the five year period from 1936-1940, 78 patients of a series of 120 cases were treated by surgery plus radiation in some form. In this total series of 120 cases there was one operative death. There were seventy-eight 5 year survivals—five with recurrence and 73 alive and well; thus giving a five year rate of 65% survival and 60.8% alive and well. This is the highest five year rate of the total series.

Although statistically the only figures which we consider to be of conclusive value are those taken from the total series of consecutive cases, regardless of extent of disease and type of treatment, nevertheless a study of smaller groups which have received the same types of treatment is at least interesting and at times quite indicative. Thus, in this complete series of 120 cases, 75 received complete hysterectomy combined with radium or X-ray or both, with a five year survival of 73.4%. Of these seventy-five, 21 were treated with both radium and X-ray preceding, and 22 were treated with both radium and X-ray following complete hysterectomy, with little or no difference in five year survivals, and with a percentage about the same as that of the entire group. One was treated with X-ray alone and 4 with radium alone, preceding hysterectomy; and post-operatively, 14 received X-ray alone, and five radium alone. The five year survival rate of this group of 24 who received only one or the other form of radiation either before or after operation, is considerably lower than that of the other group of 43 who received both radium and X-ray either before or after the complete hysterectomy.

By far the best results were found in a small group of eight patients who received pre-operative radium and post-operative X-ray treatment. Of this group at the end of five years seven were alive and well, no deaths, no recurrences and one case was untraceable, thus giving a survival rate of 87.5%. Of course, this particular group is too small to serve of itself as a basis for any certain conclusion, but it is at least indicative; and this indication is strengthened by the fact that other clinics have recently reported their

best results from this same sequence of radium, operation and post-operative X-ray. Thus Dr. Hundly of the University of Maryland has recently reported 32 cases treated with pre-operative radium, 21 of whom also received post-operative X-ray with a five year survival of 84.4%. The Jefferson Clinic reports a five year survival rate of 85.2% in a group of 27 who were treated with pre-operative radium application; and with post-operative X-ray when at operation, the disease was found to be extended beyond the uterus.

One other point in this study of results deserves mention and comment. In the series from 1935-1940, 12 patients were treated by complete hysterectomy without any radiation therapy. These 12 cases were considered to be early cases; in fact, it was precisely because they were considered to be early cases that the procedure of complete hysterectomy without radiation was followed and comparatively better results would quite naturally have been expected. And yet of the twelve, two died of recurrence within five years and one case was untraceable, thus giving a five year survival of only 66.6% as compared with 73.4% in the group of 75 who were not considered to be early cases and received some supplementary form of radiation. Once again, even though because of the limited number of cases, the results are not conclusive, they are a strong indication that all cases should be treated by the combined methods. The intrinsic reason urging this procedure is quite clear. We simply do not know before operation that a cancer is early. We simply do not know the extent of local involvement until the uterus has been removed and examined. Moreover, the argument against this procedure is far from conclusive. Some authors advocate the use of pre-operative radium only on the more highly malignant types of tumor, contending that the lower grades of malignancy are more resistant to radiation and hence that pre-operative radiation therapy has no advantage in the treatment of tumors of the lower malignancy type. In a study of the uteri and adnexa removed from 67 patients who had received from 4000 to 4500 mg. hours of radium pre-operatively only 19 showed no residual malignancy. Of the nineteen, seven were Grade I, five Grade II, two Grade III, one Grade IV, three adenoacanthoma, and one not graded. In other words, twelve of the nineteen were of the lower grades of malignancy; and yet the same radiation effect, destruction of the disease, resulted in all grades. These findings would indicate that pre-operative radiation is of advantage whatever the grade of malignancy and that its use should not be restricted only to more highly malignant tumors.

To sum up. The highest five to twenty year survival has been in patients treated with complete hysterectomy. In the latest series reviewed, the survival rate in patients treated with complete hysterectomy and some form of radiation was higher than any previously attained with hysterectomy alone. When used only pre-operatively or only post-operatively the actual results do not favor the use of one method

over the other. In theory, there are advantages in applying radium before operation and using X-ray post-operatively; and the actual results in one small group treated with this sequence show the highest percentage of patients who after five years are alive and well with no recurrence of the disease.

Complete hysterectomy, then, should still be regarded as the basis of any plan of adequate treatment of carcinoma of the endometrium. Moreover, in this type of cancer, even though the results of treatment with radium alone do not compare with those achieved in carcinoma of the cervix, nevertheless radiation as a supplement to surgery has a very important place in the primary therapy of fundal carcinoma. The timing in relation to surgery, the type, dosage and method of application of radiation should be decided individually for each case.

It is true that in the treatment of endometrial cancer, improvement of surgical technique has greatly reduced the operative risk. Radiation and surgery combined has resulted in some improvement of the survival rate with definite indications of even greater improvement in the years to come. This is solid ground for optimism. Nevertheless, in the present state of our knowledge, or rather lack of knowledge, of the etiology of general cancer, our one hope of achieving any notable improvement in the results of treatment of carcinoma of the endometrium lies in early diagnosis and early treatment. As we all know to our sorrow the chief stumbling block in cancer therapy is the rapidity of change, with few warning symptoms, from a localized to a generalized condition. A localized tumor can be successfully removed surgically or by radiation-induced necrosis; and the majority of cases in which there is a survival without recurrence for five or more years after treatment are those in which the growth was confined to the uterus at the time of treatment. Once the condition has spread from the uterus to adjacent or distant organs or to regional or remote lymph nodes, then it is the pessimist who is the realist. Even with the most radical treatment at our command, the best we can do, in most cases, is a delaying action. The chance of permanent cure is not good. In carcinoma of the endometrium as in other types of cancer, it is axiomatic that the earlier the disease, the more difficult the diagnosis; and yet the earlier the diagnosis, the better the prognosis.

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BIBLIOGRAPHY

- Allen, Hertig, Et al: Correlation of Vaginal Smear and Tissue Diagnosis, *J. Obs. Gyn.* 54, 1947.
Ameson, Stanbro and Nolan; Use of Multiple Sources of Radium Within Uterus in Treatment of Endometrial Carcinoma, *J. Obs. Gyn. Jan.* 1948.
Corcaden; *J. Obs. Gyn.* 53, 1947.
Fremont-Smith and Meigs; *A. M. A.* 131, 805, 1946.
Geist; *S. H. J. Obs. Gyn.* 42, 1941.
Geist; *S. H. J. Obs. Gyn.* 41, 1941.

Gusberg; Precursors of Corpus Carcinoma Estrogens and Adenomatous Hyperplasia, *J. Obs. Gyn.*, 54, 1947.

Hendley, J. Mason; Adenocarcinoma of Uterus, *J. Obs. Gyn.*, 57, 1949.

Hertig, quoted by Meigs; *New Eng. Journal*, 233, 1945.

Hertig and Smith; Ovary in Carcinoma of the Endometrium, *J. Obs. Gyn.*, 56, 1948.

Hurdly, Et al; Adenocarcinoma of Uterus, *J. Obs. Gyn.*, Jan. 1949.

Masson; Carcinoma of Uterus, *Surgical Clinics*, N. A., Aug. 1947.

Nathanson; Hormones in Relation to Tumors, *Progress in Gyn.*

Novak and Rutledge; Atypical Endometrial Hyperplasia Simulating Adenocarcinoma, *J. Obs.* 44, 1948.

Scheffer; Diagnosis, Management Uterine Carcinoma, *Surgical Clinics*, N. A., Dec. 1945.

Scheffey, Rakoff, Hoffman; Evaluation of Vaginal Smear for Diagnosis of Uterine Cancer, *Am. J. Obs. Gyn.*, Mar. 1948.

Smith, G. V. S.; Carcinoma of the Endometrium, *Review of Results through 1935*.

Speert and Peightal; Malignant Tumors of Uterine Corpus, *J. Obs. Gyn.*, Feb. 1949.

Speert and Peightal; Evaluation of Adjunctive Radio-therapy in Surgical Treatment of Endometrial Carcinoma, *J. Obs. Gyn.*, Sept. 1948.

Taylor and Becker; Carcinoma of Corpus, Abstracted in *J. Obs. Gyn.*, 54, 1947.

Woll, Hertig, Smith and Johnson; The Ovary in Endometrial Carcinoma, *J. Obs. Gyn.*, 56, 1948.

New Concepts In The Management Of Cerebral Palsy

WESTON COOK, M. D.

The subject of my paper today, Cerebral Palsy, or Spastie Paralysis, has been viewed in a rather hopeless light throughout most of the history of modern medicine. This hopeless attitude has not been without a reasonable background, for until quite recently, the condition has been too poorly understood to be adequately treated.

Spastie paralysis was first described by Little as a condition present from birth and characterized by stiffness and loss of activity of muscle, accompanied by a speech defect, drooling, a scissors gait, and mental deficiency. It is certainly understandable how, in the presence of a combination of a severe physical handicap and mental deficiency, the outlook might be considered somewhat dreary.

With the appreciation in recent years that mental deficiency is not necessarily an accompaniment of the physical handicap, there has been a revision in the medical approach to the disease, and plans of treatment have been devised that have proven of unquestioned benefit.

I plan to cover today a little of the more modern thinking about the etiologic background (and thereby possibilities of preventative treatment), the present day orthopedic approach to the problem, and a little on the medical side concerning a few drugs that have been used in the treatment of Cerebral Palsy.

First, concerning the etiologic background, it has been felt and taught for many years that the single factor of greatest importance in a case of spastie paralysis was brain injury received during delivery, frequently with some implication of fault on the part of the obstetrician. While trauma still is considered an important factor, there are a number of others that are being more fully appreciated. Actually, relatively little work has been done in a good

scientific investigation of the pathology in individual cases. An attempt is being made to set up a central registry of brains of deceased cerebral palsied children, much on the order of the tumor registry of the American College of Surgeons.

From what little work has been done, it has been shown that one factor of some importance is the presence of anomalous variations in the brains. These variations range from minimal abnormalities to complete absence of entire structures.

A second recently appreciated factor has been the hemorrhagic changes accompanying Rh incompatibility of mother and child. For some unknown reason, this has seemed of some particular importance in the development of athetosis.

The third factor of importance in the development of cerebral palsy that is new has been termed the pre-maturity pressure change. The explanation of this is that incompletely developed walls of the cerebral vessels of a premature child are unable to adapt to the sudden change from a high intrauterine to a relatively low atmospheric pressure. The particular site of hemorrhage then determines the type of cerebral palsy that is seen.

From an examination of the various factors causing cerebral palsy, it seems to me there is not too much that can be done to decrease the incidence of this disease. Even in cases where the cause is known, too often the damage is accomplished before anything can be done about it.

The management of the problems of spastie paralysis, while being dabbled in by many branches of medicine, has, by and large, been the particular responsibility of the orthopedist. And this is rightfully so, for without careful orthopedic management, and sometimes, even with it, severe deformities may develop. Orthopedic treatment has gone through a

(Presented at Annual Session, S. C. M. A., May 18, 1949).

number of phases; with the development of anesthesia, and improved surgical technic, many operations for the various problems were devised and attempted. With a background of poor understanding of the actual condition present, be it spasticity, athetosis, rigidity, or ataxia, poor results were bound to follow in many cases. As a consequence, the pendulum then swung to the opposite pole of advocating no surgery whatsoever. Now, I believe, a balance is being reached of planning surgery with a real understanding of what is causing the condition to be corrected and what may be anticipated as an end result. By the use of judicious surgery, osteotomies, plastic tendon procedures, stabilizations and partial neurectomies, months of corrective bracing can be saved.

My idea of a sensible approach to the treatment of an individual problem is as follows:

1. Observe the child on several different occasions over a period of some weeks before making up your mind concerning the status of his intelligence. Use psychological testing when available, but let it be a guide only, for no psychological test can be accurate with a severe physical handicap.

I try to feel that practically normal intelligence is present before suggesting any substantial investment in hospitalization for surgery or in the limited valuable time of your technical assistants.

2. In the Army the next step would be called the "Estimate of the Situation." What is to be the first aim of treatment? Are deformities present that with correction will speed the accomplishment of aims? This is the ideal stage for surgery if such is indicated.

3. Braces have long been the stock in trade of the orthopedist in the treatment of cerebral palsy. At some stage during their treatment practically all of these cases will need bracing of some form, either as night braces to prevent the development of deformities, or as day braces to aid in the treatment program. The typical braces worn during the day work in several different ways, sometimes to eliminate involuntary motion, sometimes to take the place of weakened or paralyzed muscles. In all cases, they serve to hold the extremity (usually the lower extremity, because here stability is essential), to hold the extremity in the desired position of function.

In a child that has never stood up, I think of bracing as a way of holding the child in an upright position, thus forcing him to use previously undeveloped muscles of legs, trunk and neck. Thus, by use, he develops the strength of these muscle groups necessary to standing and walking.

4. A special exercise and training program. Here is the crux of what might be termed the new concept of the treatment of cerebral palsy. The basic idea underlying this training program is that in the presence of a normal mentality, even though the child may be unable to learn basic activities automatically because of the physical handicaps present, still it is possible to teach this child by a repetitive exercise program. Thus, he learns the activity in much the same manner that a normal child learns higher skills,

such as swimming.

So, after necessary surgery and bracing are provided, the child is considered from the standpoint of what goals are to be sought. Can he be taught to walk? Or is the handicap too great, and would it be wiser to accept a wheel-chair life and work for arm function for this activity?

Once the goal is determined, a program of exercises is set up with the assistance of trained technical specialists—physical and occupational therapists. With this program weakened muscles are strengthened, involuntary motions are diminished by relaxation and gradually, motion patterns become habits.

5. In addition to physical and occupational therapy, many cerebral palsied children will need help in learning to speak properly. Many factors enter into these speech difficulties. Spasticity can involve the tongue and voluntary muscles of the mouth and throat. Frequently, these are partial hearing losses that make some sounds go unheard and, therefore, unspoken. In many of the children there is irregularity of diaphragmatic motion that makes for difficult speech. Trained speech therapists can properly evaluate the various factors and can sometimes produce truly amazing improvement.

These five points constitute a basic approach to an individual, uncomplicated cerebral palsy problem. We have skipped special problems that may arise: eye problems, feeding problems, control of convulsive seizures—any one of which may prevent undertaking a training program. Seizure control, especially, is so very important that we could well spend the extra time on it alone. Suffice it to say that each of these problems must be controlled in an appropriate medical way before undertaking the training program.

In the field of internal medication, in the treatment of cerebral palsy, many different drugs have been used. Some drugs are of great value in seizure control. Others, such as vitamins, are useful for their general health value. I want to devote just a few minutes to three preparations that have been widely advocated as of great value.

First, I should like to say just a word about Prostigmine, or to be more accurate, Prostigmine hydrochloride. Several years ago, on apparently good theoretical neurological grounds this drug was considered for use in the treatment of cerebral palsy. Before an adequately controlled and scientifically run series of treatment cases could be properly evaluated, articles began to appear in lay publications about the "wonder drug". So great was the furor that arose and so insistent the parental demands that practically every cerebral palsy child in the country was tried on this treatment. The storm has now subsided, leaving Prostigmine now about where it was in the beginning—a pretty good drug to use with post-operative abdominal distention.

Shortly after the reign of Prostigmine, a new star appeared on the horizon in the form of glutamic acid. This drug, it was claimed, would practically cure mental deficiency. I know it is useless to go further

into that subject. The use of glutamic acid has been pretty largely discontinued.

About one year ago, there first appeared in American literature reports concerning the effectiveness in cerebral palsy of a new drug named Tolserol. This had first been described by Berger and Bradley in England, under the name of Myanesin. Because of the opportunity for controlled observation of a large number of these cases, a supply of the drug was allotted to us for experimental use. This experimental work has been going on since August of last year.

This presentation is not intended as a report on this work, for we do not feel that adequate material has been amassed and observed for a sufficient period of time to draw definite conclusions so this report is intended only as a preliminary report in generalities on the use of Tolserol and its effectiveness.

Approximately 40 cases have been treated with Tolserol for a sufficient period of time to be worthy of consideration. The dosage program ranged from .50 to 2.0 grams of the powder in tablet form, administered orally each day.

In each of these cases an attempt was made to secure some method of objectively measuring the progress of the patient while under treatment. Before beginning treatment, each case was given a set of timed tests, varied according to the individual abilities. At intervals throughout the treatment program, these tests were run again by the same technicians—physical and occupational therapists. Abilities that were attempted to be tested were hand use, leg use and speech. In addition to these tests, routine blood and urinalyses were done at intervals throughout the treatment. Generalizations and impressions of patients, parents, and technicians were recorded. The cases treated were in the diagnostic categories of athetosis and spasticity, and these were about equally divided. In approximately 60 percent of cases treated, there was no change that was considered significant.

In 40 percent of cases, definite improvement was noted.

The greatest change and the most consistent improvement appeared to be in cases of athetosis with tension. Of all cases treated, some lasting as long as several months, there was no instance of any untoward reaction to the medication. Insofar as results are concerned, it is to be stressed that this is not our final opinion concerning the value of this drug, but is merely our impression at the present time.

In each case, there is so great a desire to see improvement that it is difficult to prevent this factor from coloring one's impressions.

Undoubtedly, another factor that will tend to lead us astray is the fact that in most of the cases, greater efforts to obtain proficiency are made in the particular activity while under treatment. Despite this, however, it has been our feeling that Tolserol was at least worth a clinical trial in each case, particularly in view of the relatively low cost and the absence of deleterious side effects.

Finally, I would like to close on a little different note. For many years we have seen the entire problem of cerebral palsy viewed in a completely hopeless light. With the realization that all of these children were not feeble-minded and that they could be treated, there has developed, particularly in lay groups interested in crippled children and in the lay press, an attitude that these cases can be cured.

To me, this is an even more cruel tendency than saying there is nothing to do, for it raises the hopes of parents only to certainly drop them to greater depths. This can best be prevented by a realistic outlook of what may be expected.

Yes, if he has a normal mentality, the child can be taught many things—possibly to walk, to dress, and feed himself, to speak understandably. To be normal—No, but certainly far better off than without these accomplishments.

Meningitis Of Aural Origin

CASE REPORT

RICHARD W. HANCKEL, M. D.
Charleston, S. C.

The case I wish to present to you this morning concerns a 21 year old white male who was admitted to Baker Sanatorium on November 24, 1948 at 9:30 p. m. He was first seen by me the following morning about 9:30 a. m.

He was irrational on admission and so the history was obtained from his mother. She stated that the patient had been perfectly well until about four days before admission when he had developed a cold. On the morning of November 24th he developed a severe headache on the right side and fever. He became progressively worse rapidly and was admitted to Baker at 9:30 that evening in a semi-comatose state. When he roused he was irrational.

In his past history, his mother stated, and her statements were checked with hospital records, that he had had "ear trouble" in his right ear since two years of age. At eight years of age (1935) he had a right simple mastoidectomy done at Baker and had progressed satisfactorily except for discharge from the right ear until September 1944 when he was admitted to the Isolation Department at Roper with a diagnosis of meningitis. He was treated with chemotherapy at that time and had an uneventful recovery. The final diagnosis at this time was meningococcal meningitis. However, his spinal fluid culture was negative (the specimen was not obtained until he had been on sulfadiazine for 24 hours) and I feel sure that this diagnosis is in error and that the meningitis was of aural origin. As a matter of fact the consulting otologist at that time made a note to that effect on the chart.

He moved to California shortly after this and in March 1947 he had a recurrence of meningitis. He was admitted to Stanford University Hospital in San Francisco and after the meningitis was controlled with chemotherapy he had a residual vertigo. His physician there, wrote that he (the patient) claimed no hearing on the right side but his Weber was referred to that side. Also the labyrinth on the right responded to caloric stimulation indicating that the inner ear was still functioning. His physician further stated that there was a pulsating mucopurulent discharge in the canal and a very red promontory. The drum membrane was almost entirely gone, a remnant of malleus handle remained. A revision of the previous mastoidectomy was done at this time and revealed that dura in the region of the squama had been exposed at previous surgery extending over an area of about one square centimeter. An endaural approach was used and a modified radical mastoidectomy was

done—i.e. the remnants of the middle ear were left undisturbed in the hopes that there would be some regeneration of the drum membrane. Also during the course of this operation it was found that in addition to the exposure of the dura over the squama, some tough fibrous tissue also covered the dura in the posterior fossa. It was felt by the operator that the lateral sinus had probably been entered at the first operation and packed off. However, no examination of spinal fluid dynamics was done at Stanford University Hospital. He made an uneventful recovery except that the ear continued to drain.

This aural discharge persisted to greater or less degree up until the time of his present attack when it was increased.

On examination at Baker on the morning of November 25, 1948 (the day after admission) one noted a white male apparently of stated age, in a semi-comatose condition, and having marked nuchal rigidity. His temperature was 104.2 rectally. Examination of his right ear revealed a depressed mastoidectomy scar posteriorly and a well-healed endaural scar. A moderate amount of thin watery discharge was present in the canal and the mucous membrane over the promontory was acutely inflamed. A small rim of drum membrane remained, no ossicles could be demonstrated.

In view of his past history and present findings it was decided to have Dr. Kredel in on consultation as we anticipated that we might need him at the time of a contemplated third operation if a brain abscess was uncovered. He saw the patient that morning and did a lumbar puncture. The fluid was cloudy with an initial pressure of 280-300. About 200 cc were withdrawn and the final pressure was 160. There was no rise in pressure on compression of the right juglar, but a free rise and fall on compression of the left. Examination of the spinal fluid showed a total cell count of 3,152 with 99% polys. Culture was positive for pneumococcus type #17.

Blood counts ranged from 22,000 total white with 89% polys at the onset to 6,100 with 52% polys and 48% lymphs on November 29, 1948. Urinalyses were consistently within normal limits.

X-rays revealed evidence of erosion of the apex of the right petrous.

On admission he was put on penicillin 50,000 units every 4 hours intramuscularly and 1 gram of sulfadiazene every 4 hours with sod. bicarbonate. In addition to this he was given sulfadiazine gms. 2.5 intravenously the following morning.

A rapid regression of his symptoms followed. He

became clear mentally and afebrile on the 4th day.

A further revision of his mastoid was done on December 3, 1948 after he had been afebrile for four days. A post-auricular incision was made and the skin reflected forward. A large dehiscence of bone over the dura in the region of the squama and tegmen was found and granulations were present on the dura. Surrounding bone was removed until normal dura was uncovered. In the region of the knee of the sinus hard sclerotic bone was removed to a depth of about one-half c.m. and no sinus was discovered. It was assumed that the sinus had been completely obliterated at the original operation in 1935. The remnants of posterior bony canal were removed. The rim of drum was removed and the lateral opening of the Eustachian tube in the middle ear was curetted. No ossicles could be identified. A subarcuate lead of cells into the petrous was noted and these were entered with a fine curette. These cells were not particularly necrotic, but were rather hard and brittle. This could perhaps be accounted for by the prompt and intensive sulfadiazine therapy. A modified Panse flap was cut and the flaps sutured in place, care being taken to cover as much of the dura as possible with the upper flap. The cavity was packed with vaselin gauze packing and the wound closed with skin clips. A dry dressing was used.

The clips were loosened four days after operation. The lower angle of the wound was not well approxi-

mated and this was resutured with two black silk sutures under local anesthetic. The packing was removed and a dry dressing applied.

Following this he made an uneventful recovery and was discharged home December 11, 1948, eight days after operation and eighteen days after admission.

He has been seen in the office at fairly frequent intervals. Aside from the removal of granulations with 100% silver nitrate his course has been uneventful. There has been no discharge present for the past three weeks. No audiogram could be done before operation, but one done after operation shows only an 18.8% loss on the operated ear and a 4% loss on the normal side.

This case is of interest from several aspects: 1. There has been done on this one individual a simple, a modified, and a radical mastoidectomy. 2. Both post-auricular and endaural approaches have been used. 3. He has had three attacks of meningitis of aural origin and in the last two of these the attendings have resorted to surgery. Whether this will be his last attack remains to be seen, but I do believe that a post-auricular approach and a radical operation offers less chance of recurrence because the skin flap can be more accurately placed over the exposed dura, and in doing a radical an attempt at closure of the lateral orifice of the Eustachian tube can be made. If this is successful it will prevent direct extension of the infection from the nose and throat to the middle ear.

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**TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION**

1949

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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SECRETARIES AND NURSES

The reaction of the public to a physician and his work is affected to a considerable degree by the attitude and demeanor of his secretary and his nurse.

Realizing this fact, at least one state medical association has promoted a state wide meeting of doctors' secretaries and nurses. At this gathering speakers discussed the various phases of the physicians work and the way in which the office personnel might help or hinder his relations with his patient. Answering the telephone, making appointments, collecting fees, soothing the dissatisfied patient, explaining the physicians tardiness or absence, helping with office treatment—all of these points were discussed.

It appears to us that such a conference would be a distinct value, particularly at this time when efforts seem to be directed toward smearing the physician and his work. To arrange such a meeting would not be difficult but it would be of little value unless it was supported by the members of the Association who would not only allow but would urge their office personnel to attend.

If doctors throughout the state want such a meeting they are asked to write to the Secretary and say so.

CODE OF ETHICS

At the last meeting of the House of Delegates of the American Medical Association, the Code of Ethics of the A. M. A. was revised. As we sat listening to the arguments concerning proposed changes, an older physician turned to us and made a very pertinent observation.

"After all is said and done, the only Code of Ethics we need is the Golden Rule. If a man is a gentleman he doesn't need a Code of Ethics—if he isn't a gentleman, he won't abide by it anyway.

How true!

THE STATE AND THE INDIVIDUAL

At the recent bicentennial celebration of Washington and Lee University, South Carolina's own James F. Byrnes delivered a challenging and thought-pro-

voking address. In the closing part of his speech he discussed the place of the state and of the individual in the future life of this nation. His thoughts are so in line with ours—and so much better expressed—that we take pleasure in presenting them:

"Here under the spiritual influence of Washington and Lee we do well to give thought to the men and women who settled this country. They came here to avoid the tyrannies of monarchies and enjoy the blessings of liberty. They were practical idealists. They kept their eyes on the stars but kept their feet on the ground. For a century and a half their sterling qualities were emulated by the American people, but today their philosophy of life and their views of government seem forgotten or ignored.

"Every segment of society is demanding special privileges—the farmer wants higher prices, the wage-earner wants increased wages, pensions, and hospitalization. Too many people want more pay for less work. We are going down the road to stateism. Where we will wind up, no one can tell, but if some of the new programs seriously proposed should be adopted, there is danger that the individual—whether farmer, worker, manufacturer, lawyer, or doctor—will soon be an economic slave pulling an oar in the galley of the state.

"Unfortunately each political party tries to out-promise the other. Some people even go so far as to say that it is unsocial to save. They want to lean upon the state, yet the state has to lean upon each one of us.

"Too many people are trying to transfer power to government. That is justified in war but not in peace. In time of peace the state must exist for the individual and not the individual for the state. Power once transferred to government is difficult to recover. Power intoxicates men. When a man is intoxicated by alcohol he can recover, but when intoxicated by power he seldom recovers.

"We are not only transferring too much power from the individual to government but we are transferring too many powers of State governments to the Federal Government.

"We should not have the Federal Government

regimenting our lives from the cradle to the grave.

"Some of the proposals now suggested which would curtail the liberties of the people are offered in the name of public welfare and are to be made possible by Federal aid. That phrase is an opiate. It is deceptive. It leads people to believe that Federal aid funds come from a Christmas tree. The truth is there are no Federal aid funds except those taken from your pockets. If the people generally will ever come to understand this, there will be less demand for Federal aid.

"Beware of the Greeks bearing gifts. Beware of those who promise you something which does not belong to them and which can be given to you only at your own expense or the expense of another who may not produce to make the promise good.

"The States may have failed to make adequate expenditures in some fields. That does not justify the transfer to the Federal Government of powers it was never intended to exercise. In every State there has been increased expenditures for welfare purposes. Give the States a chance.

"If the Congress, instead of seeking new ways to spend the money which is being collected from the people, would repeal some of the excise taxes, the States could then levy additional taxes in that field. They could provide for many worthy causes and still leave the people with more money and more liberty.

"In the days ahead of us, there will be a struggle between those who believe in individual freedom and those who would subordinate the individual to the dictates of government. There will be a struggle, too, between those who would transfer even greater powers to the Federal Government and those who would stand by the Constitution and its reservation of powers to the States.

"As citizens, you will be called upon to help solve these problems. You will bring to their consideration trained minds and stout hearts, and whatever may be your conclusion as to the proper solution, I am sure you will discharge your duty in a manner worthy of the spiritual and intellectual heritage bequeathed to you by the patriotic Americans for whom this university is named—Washington and Lee."

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

CHARTER ISSUED MEDICAL CARE PLAN

On July 25, the Secretary of State for South Carolina issued a Charter from the State to the South Carolina Medical Care Plan. The application had been approved by the Insurance Commissioner. "The Plan" is therefore, now a corporate body, a legal entity, and may begin operation as soon as the necessary preliminary organizational work is completed.

The amount of that work is considerable, and all of it requires meticulous care in the doing. The Committee in charge of physician enrollment, Dr. Wyman King, Chairman, has met and is ready to go ahead with the job of securing signatures of participating physicians as soon as the form of the Agreement is approved by the Board of Directors.

The Committee on Contracts and Forms has prepared a draft of the Agreement and is at work on the Subscriber's Certificate and other forms necessary to begin operations. In doing this work the Agreements and other documents in use by Plans in other States are being examined, and many of their applicable provisions will be incorporated in ours.

The Committees have kept in touch with the office of the Director of Associated Medical Care Plans, Chicago, and have received great assistance from that source.

The Actuarial Committee has secured preliminary estimates, after calculations by qualified actuaries, based on our approved fee schedule, of the subscription rates which must be charged in order to render

the service specified in the By-Laws and to be covered by the Contract.

While the report on this is by no means final and will be rechecked and carefully studied before approved by the Board of Directors, it is extremely favorable, in the sense that the subscription rates, as estimated, are small enough to be attractive to the very low income groups.

Of prime importance now and in the next few months, is the spirited interest of the physicians. At least 50% of all the doctors of medicine in the State—not simply of Association members, must be enrolled as participating physicians before the Plan can begin operation. This means that to assure the requisite number, considerably *more* than half the members of the Association will have to enroll. The members will contribute much to the success of the effort to begin early operation, by informing themselves on the methods of the Plan's operation and the provisions of its Enabling Act, By-Laws and fee schedule. The fee schedule was published in the June issue of the Journal—the By-Laws in the February issue.

Elsewhere in this Department will be found the first in a series of questions and answers designed to explain and clarify the important features of the Plan and its operation. The series will be continued in subsequent issues of the Journal, and any members of the Association who have other questions concerning the Plan are invited to send them to the Public Relations Department for inclusion in the Journal, or for special attention and reply if requested.

BLUE SHIELD FACTS

Q. What is the South Carolina Medical Care Plan?

A. The South Carolina Medical Care Plan is a non-profit corporation without capital stock, organized and chartered under a special Act of the legislature of this State. Its Charter was issued by the Secretary of State of South Carolina on July 25, 1949.

Q. Who sponsored the Plan and what is its purpose?

A. The Plan is sponsored by the South Carolina Medical Association for the purpose of furnishing prepaid medical care to the public in South Carolina, at rates which individuals in the lower income brackets can afford to pay. The State Medical Association, through its Committee on Medical Service, was responsible for introduction of the enabling Act in the Legislature and for the continued necessary effort to have it enacted into law.

The object being as stated, the Plan is not organized for profit. Since it does not have to make money for stockholders, and is required to earn only an amount sufficient to meet necessary expenses and maintain an adequate reserve, its rates to subscribers can be correspondingly reduced. For the same reason, the Plan is exempted from the payment of taxes.

For those subscribers whose total annual family income is \$3,500 or less, the physician's fee will be paid in full by the Plan, according to a fixed fee schedule. This is the second distinct advantage for the lower income group.

To those whose total annual income is more than \$3,500, the physician may charge whatever he would regularly charge. The Plan will pay him the amount fixed in the fee schedule to be applied as a credit, and the balance, if any, will be collected by the physician from the patient.

Q. Who owns and controls the South Carolina Medical Care Plan? How is it financed?

A. The South Carolina Medical Association appropriated the sum of \$10,000 as the initial working "capital" to enable the Plan to begin operation. If additional sums are necessary, they will be raised through the efforts of the Association or its individual members.

The Plan is fully controlled by the State Medical Association. Its members are the members of the House of Delegates of the Association, and the By-Laws provide for an annual meeting of the membership at the time of the annual meeting of the State Association.

Between meetings the Plan is operated by a Board of Directors of fifteen. Of this number, at least eight at all times must be doctors of medicine and actively engaged in practice in South Carolina. The other seven are chosen from the non-medical public. All Directors are nominated by the Council of the Medical Association, and

elected by the House of Delegates of the Association.

Q. Are all members of the Association required to join the Plan as participating physicians?

A. No. Members of the Association are not required to join the Plan as participating physicians, but all are invited and urged to do so. Before it can commence operation, at least 50% of the doctors of medicine in South Carolina must agree to participate in the Plan's activities. This includes all doctors of medicine actively practicing in the State, whether members of the Association or not; therefore, in order to assure active operation of the Plan, it will be necessary that considerably more than 50% of the members of the Association agree to participate.

Q. How will the individual physician benefit by membership in such a Plan.

A. There will be benefits directly through (a) assurance of being paid an adequate fee for his services by patients (subscribers to the Plan) who otherwise could not pay, or would not pay; and (b) additional patients from among the lower income group who, without such protection, perhaps would not seek services unless absolutely necessary.

A physician will benefit also indirectly, through the better relations of his profession with the public, generally, which will naturally be established as professional services are made available to more members of the public, who otherwise would not receive them except on the basis of charity.

Q. Are such Plans in existence in any of the other States?

A. As of March 31, 1949, there were 59 prepayment medical care plans operating in 46 of the United States. The types of Plans and the extent of coverage which they offer, vary. This left only South Carolina and Georgia without Plans in actual operation.

Q. What is Blue Shield?

This is the name and a symbol which have been chosen to identify medical prepayment care plans in the United States which meet certain requirements and measure up to standards established under the supervision of the Council on Medical Service of the A. M. A. It is the companion and counterpart to Blue Cross, which represents the plans similarly organized and operated for furnishing hospital services.

Q. Will this Plan entail spending a great deal of time with paper work and red tape?

A. Participation with the Plan will, of course, entail some paper work in the doctor's office, most of which, however, can be handled by the secretary, and this will be kept to a minimum. The additional work which will be required certainly will

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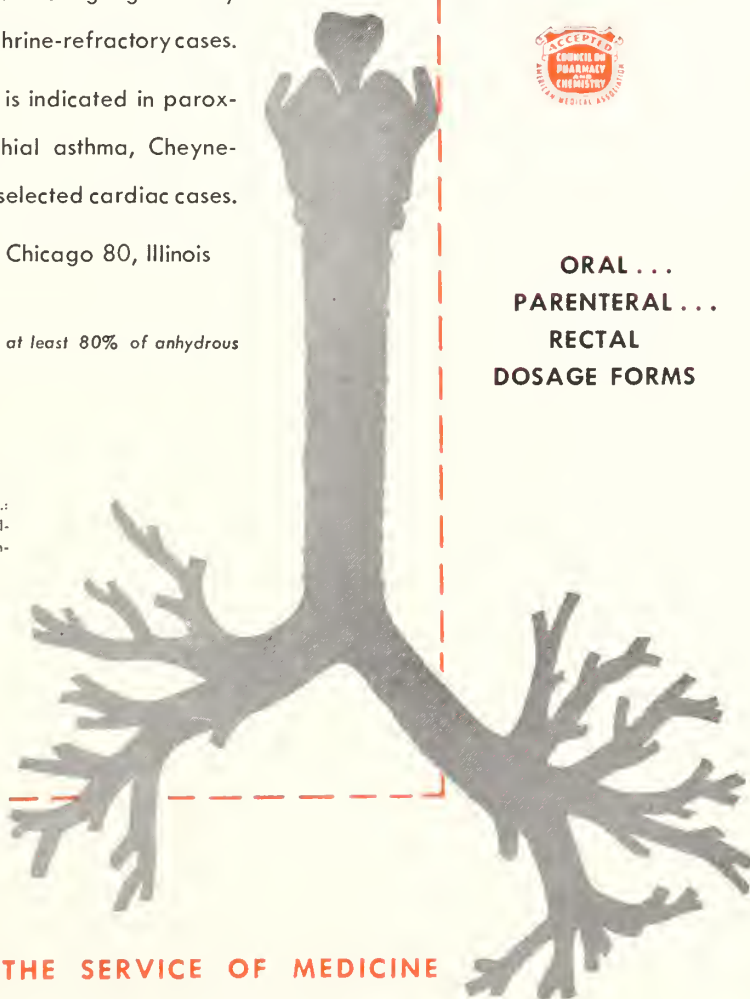
1. Rockemann, F. M., in Cecil, R. L.: Textbook of Medicine, ed. 7, Philadelphia, W. B. Saunders Company, 1948, p. 539.



ORAL . . .
PARENTERAL . . .
RECTAL
DOSAGE FORMS

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE



not compare with the red tape which would be involved under a system of government health insurance.

Q. Will it require any financial obligation on the part of the doctor?

A. No. There are no dues or payments of any kind to be made by the physician.

Q. Will the Plan cover all types of treatment, or is it limited to specific types of treatment, and does it apply anywhere except in the hospital?

A. The Plan will cover general surgery including gynecological, orthopedic, that of the eye, ear, nose and throat, neurosurgery, and urological examination and surgery, in the doctor's office or clinic, and in the hospital; and obstetrics (delivery and early postpartum care only) in the home, the doctor's office or clinic, and in the hospital.

Q. Will the Plan cover anyone who desires to become a subscriber, or is it designed so as to limit membership according to income?

A. Any employed person may become a subscriber, provided he or she enrolls as a member of a group not organized especially for procuring insurance. While the benefits of the Plan will be more attractive to those of incomes less than \$3,500 per year, there is no plan or purpose to limit membership according to income.

Q. Once a physician joins the Plan, is he compelled to remain a member? And if he is dissatisfied, who settles any questions which may arise between Plan and physician?

A. No. A participating physician may sever his connection with the Plan after notice to that effect a sufficient length of time in advance, this to be determined and specified in the Contract between Plan and physician. Any dissatisfaction or questions arising between the Plan and the Physician, or between the physician and the patient, are to be submitted to, and settled by the Central Professional Service Committee of the Plan.

Q. Will the physician have any choice regarding treatment of patients who are subscribers, or must he treat anyone who comes to his office, although some may be persons whom he has not treated previously?

A. The physician will have the same choice as to whom he will accept as patients among subscribers to the Plan, as he has now with respect to patients generally. He would not be permitted to refuse to treat a patient for the reason that the patient is a member of the Plan, but otherwise his freedom in this regard would not be restricted at all.

Q. How would the physician be chosen to render services under the Blue Shield Contract?

A. Exactly in the same manner as now—by the patient. A list of the participating physicians in any

community will be available to subscribers at all times, and from this list the patient will select the physician of his choice.

Q. How may a physician become a member?

A. By signing the Agreement with the Plan, whereby he contracts to render professional services for which he is qualified, to subscribers to the Plan and their covered dependents, in return for fees to be paid him by the Plan according to the Plan's fee schedule, and that such fees shall be received as payment in full, when the annual family income of the patient does not exceed \$3,500.

Q. Will payment for his services be made by the Plan to the physician, or to the patient?

A. Payment for his services will be made directly to the physician by the Plan, upon his statement, rendered monthly.

(To be Continued)

THE IMPACT OF SOCIALIZED MEDICINE ON THE BRITISH PHYSICIAN AND HIS PATIENT*

CECIL PALMER
of
London, England

Publisher, author, journalist, and signatory of the famous "Manifesto on British Liberty" issued by the Society of Individualists of which he is a leading spokesman.

I am not a doctor but I am very much a patient. I have had first hand evidence of American medicine and of private practice, and except that I think it is almost as dear as socialized medicine, I can only offer you my congratulations on the services that you are rendering to mankind.

Mr. President, you have been good enough to say that I will try to paint a picture of Socialism in Great Britain—that's a rather general thing to attempt, and in this specialized audience I don't think I shall accept that invitation.

I have done it many times in the United States already, but it seems to me that you would be more pertinently interested if I more or less concentrated on socialized medicine in Great Britain.

Let me say in the first place that I have from the very beginning of socialized medicine in Britain bitterly and strenuously opposed it, and I would ask you to believe that I have opposed it on moral grounds, and it is my belief, ladies and gentlemen, that it is on moral grounds, primarily, that you must fight to preserve private practice in medicine.

In Britain, the doctors were winning all along the line, and it still is a mystery to me, as it is a mystery to many of my fellow countrymen, and it is a mystery to many members of the British Medical Profession—

*Address by Mr. Cecil Palmer of London, England before the Conference of Presidents in Atlantic City on June 5, 1949.

how it came about that at the eleventh hour, the medical profession gave up the ghost.

I believe it was due to the fact that the Minister of Health, in our present Socialist Government, was able to divert the issue from the moral basis to the business. He was able to make the doctors, by a very clever political formula, to discuss terms of service, whereas the doctors would have been on stronger ground if they had said there were no terms of service, under which they would degrade medicine by serving a state salaried medical service.

I go further, Mr. President and ladies and gentlemen, and say that the medical profession in Britain made a contribution to the servile state that had not been exceeded by any previous measure of nationalization in my country. When the doctors were out and free, we had a chance; but when the doctors came in and made themselves the servants of the state—then we, indeed, had come to a position in which it would seem, at this moment, that we cannot possibly recover.

State paternalism is a curse and if I may be facetious, I may say from my own observation that socialism in Britain—socialism in practice, ladies and gentlemen, which is a very different thing from socialism in theory—I would say that socialism will work only in heaven where they don't want it, or in hell where they have got it already.

Two Trends Offer Hope

I believe there are two trends operating conjointly in Britain today which may save us. The one is, what I would term—The Women's Revolt, and the other is a purely economic one which is that socialized medicine is financially top-heavy.

But do you know, Mr. President and ladies and gentlemen, that the first year of operative socialized medicine in Britain is costing my impoverished country one billion dollars. And that is for socialized medicine alone, and when I tell you that socialized medicine represents only one-ninth of the total bill of social services throughout Great Britain, you will get some indication of the hopeless position we shall be in, financially, at the end, shall we say, of another year.

Indeed, Sir Stafford Cripps, to whom at least I pay tribute of sincerity, has already assured the nation that we cannot carry this heavy socialized medicine bill without some rearrangement of the contributions. One billion dollars a year! . . . for a service that is not to be compared with the practice of medicine as we had it before the socialists got the grip on us; and I would remind you, ladies and gentlemen, above everything else—to remember that Lenin, who was the architect of communism—Lenin said, that if he could control the doctors, he had the people.

And I am going to show to you that is a very great truth, and that it is integral to socialism in any country. If the doctors won't play, socialism won't work.

In other words, socialized medicine, in my humble judgment, is an integral part of socialism and fascism in practice. But I am not going to stress the obvious financial instability of socialized medicine in Britain. I believe that the common sense of the British people will find its own solution to that problem at any rate because we are being overtaxed and undernourished every day in every way.

I am going to take it on much broader grounds. I am coming back to my moral basis, and I say, without fear of honest contradiction, that socialized medicine in Britain has done two major things. In the first place, it has revolutionized the status of the doctor. His livelihood, his professional advancement, his allegiances and loyalties are now commandeered by the state, his new master, who pays him once a quarter—his salary from the contributions collected from the patients.

And the second major thing it has done is that it has destroyed the relationship between the doctor and the patient.

I do not know with any measure of certainty what are the canons of medicine in America, but I know, and I assume that you know, too, that in British medicine every medical practitioner is bound insolubly to an immemorial oath. And that oath—the Hippocratic oath—binds every medical man to observe secrecy and privacy in the relationships professional between the doctor and the patient. And that has gone by the board.

Power of Statutory Instrument

I am one with many in Britain who envisaged that possibility and because of it, when the bill was passing through various stages in the House of Commons, through members of Parliament, had it challenged directly to the Minister of Health himself and, in response to that challenge, he gave a categorical assurance that privacy and secrecy in socialized medicine would be strictly observed.

Mr. President, ladies and gentlemen, within three weeks of the passing of that act, that same socialist Minister of Health issued what is termed in Britain a Statutory Instrument. I should explain to you in parenthesis, that a Statutory Instrument is one which any minister of the crown can exercise and issue, and when issued has all the force of law, is above the rule of law, cannot be challenged in the courts, and has as much weight as any regularized act of Parliament.

And to show you how far my beloved country has trodden the crooked path that leads to the servile state, I would tell you that the Statutory Instrument to which I am now going to refer is Number 506. In other words, we had previously 505 Statutory Instruments, delegated legislation, which have never been discussed or debated in the House of Commons but which operate on the citizens of Britain as though those instruments were literally acts of Parliament.

Now the Statutory Instrument 506 which was issued three weeks after socialized medicine became operative, read like this:

It was headed: Terms of Service.

The terms of service require every practitioner to keep records of the diagnosis and the treatment of all his patients, and to make such records available to the local Lay Council. The women, ladies and gentlemen, were the first to see the harsh impact of that implication. And they are in revolt in increasing numbers, because, if I may put it in a facetious way, the position has arisen thousands of times already where Mrs. Brown living in Block A is a patient, and Mrs. White living in Block B is a member of the Local Lay Council, and I leave it to your imaginations to envisage the potentialities and the possibilities for a little light gossip at the expense of Mrs. Brown's health.

Socialized Medicine Cannot Work

Socialized medicine in Britain is not working and cannot work. There are not enough doctors; there are not enough nurses; there are not enough hospitals; there are not enough clinics.

Every doctor in Britain, who practices in an industrial area, is expected to take 4,000 patients and every doctor in Britain practicing in the rural areas where traveling is longer and more arduous, is expected and indeed economically compelled to take 2,500 patients. And those doctors serving under socialized medicine receive for their professional services a per capita fee of \$3.25 per patient per annum.

The situation, quite frankly, is this. That when you remember that every professional man in Britain who earns more than \$4,000 a year—not a very princely salary—pays roughly 45% in direct income tax, you will see that per capita fee doesn't keep the wolf from the door, and indeed it is true, and the British Medical Association is my authority on this, and I have worked in the closest contact with them, that there are many doctors up and down the length and the breadth of the British Isles today who are not only not making a living but are living on capital. Many of them are living on bank overdrafts. That is the economic situation for the doctor in Britain under socialized medicine, and so acute and urgent has the problem become that the British Medical Association has lodged with the Minister of Health a demand for an immediate increase in the per capita fee. The doctors' hope of getting it is exceedingly remote, because the same Minister of Health has already, at the end of ten months of operative socialized medicine, issued instructions to hospital authorities to cut down their expenditure and the result is that in many hospitals in Britain today they are cutting out wards and other services simply to make ends meet financially.

Two Significant Considerations

But I want to put it to you, and I count it a great privilege to be able to put it to you—I want to put to you two significant considerations. The architect of socialized medicine in Great Britain was Lord Beveridge—a very sincere man; a very old man. As a research student, I suppose, incomparable. But he be-

lieved, and I imagine still believes, that the State can do for you better those things you should want to do for yourself. Anyway, all his inspiration came from Germany, which country, if I may say so, was, in every sense, the Father of Social Services. And in his report of 300 printed pages, a report which I believe I am almost unique in having read from cover to cover, he made two assumptions. And I beg you to listen with the greatest care to the implications of all I am now going to say, because this is the side of socialized medicine which the press and the radio and the platform, if they mention it at all, soft pedal.

The report of Lord Beveridge contained, as I have indicated, two assumptions, and those assumptions, I may say, are embodied in the present act. The assumptions were called Assumption A and Assumption B.

Assumption A is that it is the duty of the patient to keep well, and

Assumption B is that it is the duty of the doctor to exercise harsh certification which, in plain English means that it is the duty of the doctor to return his patient to his job as quickly and as cheaply as possible.

You may think that I am exaggerating, but I will now ask you to consider another piece of legislation—dedicated legislation—in Britain which again has been soft pedaled. And I believe that you will discover precisely what I have discovered—that there is something deeper and more menacing in socialized medicine than appears on the surface.

In 1947 Great Britain woke up one morning and discovered itself saddled with what was called a Control of Engagements Order—1947. It was never debated in the House—it was just a piece of delegated legislation which Ministers of the Crown can impose on my people in peace time.

Under the Control of Engagements Order every man and every woman between the ages of 18 and 50 can be and are directed by the State to take any job, anywhere, at any time, according to the State's choice. In other words, in the twinkling of an eye my people, despite their long constitution history, found themselves saddled with industrial conscription in peacetime. It was brought in in '47 because our unemployment problem then was virtually non-existent and, therefore, it wasn't in an active sense operative. But it doesn't require much imagination to see that when unemployment increases and becomes measurable, the impact of that piece of legislation is going to be devastating to the liberty of an individual.

Now, I ask you as medical men and women, to put that Control of Engagements Order, an order which for all practical purposes made null and void habeas corpus and the Bill of Rights and the Petition of Right, I ask you to put that act or that order against those two medical Assumptions, and you will see then, I think, perfectly clearly what Lenin meant when he said that if he controlled the doctors, he had the

people. You are getting, in those three things, precisely the ideal which Lenin envisaged.

Fellowship of Freedom

The medical profession in Britain, Mr. President, ladies and gentlemen, I am happy to say, is becoming increasingly aware of it. And Lord Horder, who I believe is in America at this very moment and who is, if I may say so, a personal friend of mine, never went into the scheme and by the way, I should tell you that there were roughly 2,600 doctors in Great Britain who remained outside the scheme and have never come into it. But since the bill has become operative, and Lord Horder had brought into existence an institution which is not opposed to the British Medical Association, but which is, if I may say so in a non-committal way, more or less a ginger group and I ask you to note the title which is given to that new body of medical men and women, because as the late Gilbert Chesterton said "it is a tremendous trifle."

The title of that new institution is The Fellowship of Freedom in Medicine, and Lord Horder told me just before I flew over to the states that he had already enrolled in that institution 2,500 medical men and women, and he said to a reporter in New York, I think only a day or two ago, that it had increased now to a membership of approximately 3,000.

Every doctor in Britain is discovering to his sorrow that he is now a state salaried medical servant, and that his obligations to his patients are less important and less imperative than his obligations and his responsibility were to his patients under private practice.

In Great Britain today there are over 200,000 urgent cases requiring what we call institutional treatment. You, I believe, say in such circumstances that they require to be hospitalized. And, at the same time, there are 57,000 vacant beds in hospitals—1/9th of the whole beds of all the hospitals in Great Britain, and they are empty because there are neither the doctors nor the nurses to service them.

Under private practice in medicine in Britain, ladies and gentlemen, in Britain at any rate, the hospital was considered to be the haven for the poor man and the poor woman. That privilege under socialized medicine is gone. He is no longer privileged because I would ask you to remember that socialized medicine is compulsory and that every man and woman in Britain, rich or poor, must contribute and the result is that thousands of men and women who hitherto have found finances for their own illnesses are now demanding entrance to hospitals and crowding the poor out.

The socialists have talked a lot, ladies and gentlemen, about the common good of the common man. Personally I loathe the phrase. I don't believe a common man exists, and I have short circuited that point by asking you to remember that not even socialists yet have had the effrontery to refer to the common woman.

Under socialism in Britain we have been trying to do something that is quite fantastic, and you as professional men who are guardians of liberty in the very strictest sense should know it.

Weakening the Strong

If you ask me to put my finger on the malady in Britain today, I would say without a moment's hesitation that we have tried to strengthen the weak by weakening the strong. And we have tried to legislate unsuccessful people into prosperity merely by legislating successful people out of it.

For years—as long as I can remember, my people have been poisoned with the heresy that you can have in this wicked world something for nothing. It just does not add up. And I cannot, ladies and gentlemen, remember in my lifetime any single piece of legislation that has been put over with more ballyhoo than the so-called free medical service—free—free—the patient's contribution to socialized medicine in Britain amounts to \$2,800,000 a week. If that is free medical service, I, as an ordinary businessman, ask for one that isn't because it might be cheaper and it couldn't be dearer.

The British Medical Association has told our public in Britain that under socialized medicine it is not possible for any doctor to give more than five minutes for diagnosis and treatment of any patient who comes before him. Indeed the queues in doctor's surgeries which I believe you call offices are just too appalling and painful for words. It is common for women, for example, to appear at surgeries or offices in the morning, to leave at noon not having even seen the doctor; returning in the early evening and leaving then in the evening without seeing the doctor and returning the next morning.

The Regimented Doctor

The life of the doctor under socialized medicine is the life of a glorified clerk and nothing else. All his case reports which were private and confidential and which were his exclusive property are now made out in triplicate and are made available to the Local Lay Councils and to Regional Boards. I mentioned the status of the doctor. Even in the highly individual prerogative of a doctor, namely, prescribing for his patient, he is no longer master of himself, because regional boards can override a prescription and have done so many times already. The moral and scientific degradation of medicine has been so terrible in Britain in the few short months that it has been in operation, that I tremble to think what will happen to my country if we don't come back to political sanity and make readjustments more in keeping with the hearts and souls of men and women.

As an individualist, ladies and gentlemen, I believe every man, woman and child in the universe is unique. And I believe, too, in a very real sense that the medical profession above all has a tremendous responsibility and a tremendous privilege to keep the light of liberty strong. We are living in semi-darkness in

Britain and I say at this end as I said at the beginning that I believe that the medical profession in Britain without knowing it has made a greater contribution to our serfdom than any other single piece of nationalization that has been put upon a perplexed, bewildered and war-weary public.

My only hopeful thing for you so far as Britain is concerned is that we are beginning to wake up, and if I may say so, Mr. President, in listening to the speakers who have preceded me, I did gain some measure of encouragement because at least it seems to me that your profession is aware of what must happen to your noble profession if you ever find yourselves under the state-state paternalism in Britain is sapping our vitality; it is destroying our capital and is making all of us, in one way or another, eligible for the ranks of crookdom. It is impossible in Britain, I am not exaggerating—it is impossible in Britain today to lead a strictly moral life in an ethical sense. We all have to dodge the law in one way or another in greater or less degree. And, under socialized medicine, that kind of petty misdemeanor has grown conspicuously. People are going to doctors with imaginary complaints, and indeed it is not an exaggeration to say that we are in living danger of becoming a nation of hypochondriacs.

EVERYBODY'S FIGHT*

Top officials of the Federal Security Agency have a plan for socialized medicine in America.

*Editorial appearing in the July 1949 issue of "South Carolina Business," published by the South Carolina State Chamber of Commerce.

The plan has been approved by the White House, and Security agency officials are making an all-out effort to get Congress to put it into effect.

All members of the medical profession, physicians, surgeons, specialists of all kinds, and dentists are alarmed. But the issues involve not only them. Every American is concerned.

Many arguments in favor of the various proposals to Socialize Medicine have been propounded, but the proponents have no satisfactory reply to the fact that the American people are the healthiest of any nation, including the countries where Socialized medicine has been in effect for many decades. The Socialized Medicine system, like all government-give-away schemes, is an extremely costly system and nations that have tried it have only added to their insolvency.

Socialized Medicine would be a big step toward socialism in general. A huge new government bureaucracy would be created, and there would be wide-spread destruction of our voluntary institutions. Everyone connected with the medical profession would be government-controlled—not only doctors, but countless typists, bookkeepers, nurses—the list is almost endless.

This new army of government workers might number a half million persons or more. It could wield dangerous political power. Meanwhile, the many insurance organizations now active in the health field would be destroyed.

Can any true American really want Socialized Medicine? Then it is up to every true American to enter the fight against compulsory health insurance measures before Congress—measures designed to ultimately destroy the practice of medicine as we know it today.

Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT #645

Student Hulda J. Wohltmann, presenting:—

HISTORY: Patient admitted to hospital on April 5 in a disoriented delirious state. He was a 54 year old negro man and relatives stated that he had been sick for about a week and was unable to recognize them on the day of admission.

PHYSICAL EXAMINATION: T 102, P 116, R 48, BP 60/40. Temperature was recorded as 95 rectally by another examiner. Patient was well developed but poorly nourished, acutely and severely ill, mumbling and turning his head from side to side. Incontinent for feces. Skin dry with poor turgor. Lids are held tightly shut. The left breast is moderately enlarged and soft, without nodules. The neck showed marked rigidity. Chest: Slight diminution of expansion on right side. Fremitus moderately increased over the upper half of the right lung field anteriorly and in the axilla. Bronchial breath sounds over the right upper

lung field with dullness to percussion in same area. Crepitant and coarse scratchy rales in same field.

Heart: Heart sounds could not be heard. PMI could not be located and the heart could not be well outlined on percussion, but did not appear to be enlarged. The abdominal wall was held quite rigid. No masses or organs felt. One examiner thought there was some tenderness to palpation in the costovertebral angles bilaterally. The left testicle was considerably enlarged, hard, and apparently slightly tender.

LABORATORY DATA:

Urine: (Catheterized) Sp. Gr. 1.021, alb. 2 plus. WBC 150-200/HPF, RBC 5-10/HPF. Occult blood 2 plus.

Blood: RBC 3.05 million. WBC 37,400, hemoglobin 7.5 gms.

Color index .81, PMN 92 (79% non-filamented).

Lymphocytes 7, monos 1. WBC showed heavy toxic granulation.

No immediate sickling.

Sedimentation rate 20 mm/hr. corrected.

Sputum: Brown and thick. Gram positive diplococci predominate. Also some short chain strep and gram negative rods. Gram stain of catheterized urine sediment showed 4 plus pus cells, and gram negative bacilli.

Blood urica nitrogen 94 mgms. CO₂ combining power 39 vol. %. Spinal fluid showed a cell count of 3, all lymphocytes. It was clear. Wassermann, Kline and colloidal gold negative.

Blood culture on 2 occasions showed bacterial growth identified as pneumococcus type 27.

COURSE: Patient had severe chill following administration of 500 cc. of 5% glucose and normal saline. BP rose and then declined. Dyspnea increased. Apparently only a small amount of urine was passed by patient. Large amounts of mucous were aspirated from throat, some of which had a deep bronze color. In spite of oxygen, fluids, and 250,000 units of penicillin, patient's course was rapidly downhill and the patient died during the morning of the day after admission.

Doctor Vince Moseley, conducting—

Dr. Moseley: Mr. Powell, will you give your impression of this case?

Mr. Powell: The picture presented in this case is most likely due to a septicemia caused by pneumococcus type 27 as indicated by cultural studies. The increased heart and respiratory rate, leukocytosis, anemia, dehydration, hematuria, coma, and termination are all consistent with such a condition. The question in my mind is whether this represents a primary pneumococcal septicemia or whether there is some underlying chronic disease process complicated by a terminal septicemia. Such a chronic disease process might well be bronchiectasis or tuberculosis. The information at hand is insufficient for establishing either. The enlargement of the testicle might be on an inflammatory basis and represent an acute orchitis. It is possible that there are other inflammatory lesions such as an acute pericarditis and peritonitis, all being sequelae of the septicemia. I want to mention the possibility of malignancy of the testicle. However, statistically, this patient is too old for this to be likely. Were ascheim Zondek or Friedlander tests performed?

Miss Wohltmann: No.

Mr. Powell: I want to again mention tuberculosis in considering a chronic disease which might be behind the terminal picture. Only one sputum examination was performed and that is insufficient to rule it out. The sedimentation rate is consistent with this disease.

It is noted that there were bacilli in the urine and these are most likely *E. coli*. However, similar organisms were noted in the sputum and the possibility of a Friedlander's pneumonia must be entertained. In general, however, the high blood count would be

against this process. Usually in Friedlander's infections one sees only a mild leukocytosis or perhaps even a leukopenia.

Dr. Moseley: I would not put too much emphasis on the blood count. One may get an increased blood count in Friedlander's infection. You must also remember that this patient was dehydrated and undoubtedly the blood count was taken before the hemoconcentration had been corrected.

Mr. Powell: Another possible chronic disease would be pyelonephritis following urinary tract obstruction. Is there any record of examination of the prostate?

Miss Wohltmann: The prostate is described as essentially normal.

Mr. Powell: The gynecomastia might or might not be important. It is not uncommon to see enlargement of one or both breasts after the age of 40. This could be related to trauma or perhaps be a lipoma. Enlargement of the breast is also related at times to such tumors of the testicle as choriocarcinoma.

This patient exhibited nuchal rigidity. I believe this to be on the basis of meningismus rather than a true meningitis. Such conditions are fairly common with pneumococcal infections. My final impression is that of a pneumococcal septicemia accompanying lobar pneumonia with embolic phenomenon in the kidneys. This may be superimposed on some other chronic disease process as is suggested by the patient's malnourished state.

Dr. Moseley: Could the anemia here have developed within one week's time? Does this denote any chronic disease process?

Mr. Powell: I believe so.

Dr. Moseley: What chronic disease would you consider?

Mr. Powell: My choice would be either bronchiectasis or chronic pyelonephritis.

Dr. Moseley: Miss Doyle, do you have anything to add?

Miss Doyle: I likewise believe this patient had a lobar pneumonia with septicemia. I believe that previous kidney disease is unlikely because of the high specific gravity. There is no information at hand to suggest chronic lung disease. The enlarged testicle might represent an orchitis. This could result from tuberculosis, but it could also complicate pneumococcal pneumonia or Friedlander's infection.

Dr. Moseley: Is there any other chronic disease that might cause an enlarged testicle?

Miss Doyle: A gumma might cause enlargement. However, the serology is negative and there are no other clues.

Dr. Moseley: Does severe anemia often appear with bronchiectasis, tuberculosis, or other chronic diseases?

Miss Doyle: It is not usually associated with tuberculosis or bronchiectasis and does raise the question of sickle cell disease. Is there any note that this was looked for?

Miss Wohltmann: There was no sickling in 24 hours.

Dr. Moseley: What is your final impression.

Miss Doyle: To me this patient represents a poorly nourished individual with lobar pneumonia and associated septicemia.

Dr. Moseley: Thank you. I agree that this patient probably had a lobar pneumonia with septicemia, and I believe that there is an underlying chronic disease process. It is known that in chronic diseases of the liver that there is a decrease or failure in the inactivation of estrogens, and with an excess of circulating estrogens breast enlargement or gynecomastia is frequently seen. With this in mind it is my opinion that this patient has chronic liver damage most likely a portal cirrhosis.

Dr. H. R. Pratt-Thomas: *Final Pathological Diagnosis: Lobar Pneumonia, Pneumococcal. Glomerulonephritis, Acute, Atypical. Gynecomastia. Atrophy of Testicles. Leukemoid Reaction of Spleen and Kidneys.*

The right lung weighed 2050 gm. which is considerably heavier than a normal adult liver. The upper and lower lobes were transformed into firm, solidified grayish tissue whose cut surfaces were slick.

The left breast was symmetrically enlarged and composed of a homogeneous mass of rubbery grayish-white tissue. Each testicle showed almost complete replacement of its substance by glistening grayish-white fibrous tissue.

Lung and blood cultures taken at necropsy grew an organism that was classified as Friedlander's bacil-

lus, type A. The slippery mucoid quality of the surface of the consolidated lung caused us to consider Friedlander pneumonia at the time of necropsy. Microscopic studies do not confirm this. The lung sections are filled with Gram-positive, diplococci typical of pneumococci and the other histologic features of Friedlander pneumonia are not present, so we are obliged to designate this as pneumococcal pneumonia.

There is evidence of septicemia as indicated by an acute glomerulonephritis. This is not of the usual type seen in Bright's disease, but is more fitting to one produced by a septicemia. It easily accounts for the blood in the urine.

The high leucocyte count is reflected by the leukemoid reaction which appears in the kidney and spleen.

I have no support for the idea of a underlying chronic process. I would like to confirm Doctor Moseley's impression of cirrhosis of the liver, but cannot. This would be an explanation for the gynecomastia, but on the other hand the degree of testicular atrophy will also explain it as hormonal imbalance with actual or relative increase in estrogens is the underlying factor. These testes would certainly be responsible for marked decrease in androgenic activity. The breast shows no hyperplasia at this time, simply a marked increase in collagenous fibrous tissue which is probably the end result of previous activity.

Dr. Moseley: Therapeutic agents used in the treatment of pneumonia made modify the immunological responses on which typing is based and this probably accounts for the discrepancy in the bacteriologic data.

PUBLIC HEALTH NEWS

MENTAL AND SOCIAL HYGIENE SOCIETY MEETS IN FALL

Plans for an institute on social hygiene and a program on mental health to be held in November were made at the recent meeting of the board of Directors of the South Carolina Mental and Social Hygiene Society.

The Society has set the date of its annual meeting as November 10 in cooperation with the South Carolina Conference of Social Work. An outstanding speaker will be invited for the morning session to be followed by a luncheon meeting at which time important business and legislation will be considered. Plans were also made for a social hygiene institute for November 8. The meetings will be open to the public.

Requests have come from some sections of the State for institutes on Human Growth and Development to be given in the late summer or early fall. The Board approved development of institutes in Greenville and Charleston. Miss Lucia Murchison of the State Board of Health, as chairman of this committee, will work with local groups in these areas to plan the institutes.

The following recommendations of the joint study committee from the South Carolina Mental and Social Hygiene Society and the Richland County Mental Hygiene Society will be presented to the total membership at the annual fall meeting:

1. It is hereby recommended that the State of South Carolina establish a central board, commission, department or bureau of mental health or mental hygiene to supervise, administer, and operate all state institutions for the mentally ill, alcoholics and mental defectives.

2. It is further recommended that the aforesaid department of mental hygiene be responsible for the licensing of and uniform and regular inspection of private and public institutions for the mentally ill.

3. It is recommended that the wording of the statutes and court proceedings now in use be changed wherever practicable to omit the words "insane", "insanity", "lunatic", and that terms such as the "mentally ill" or "mental illness" be substituted therefor.

Officers of the Society are: Dr. Hilla Sheriff, State Board of Health, president; Miss Ida M. Colson of Charleston, vice-president; Judge J. W. Davenport of Spartanburg, treasurer; Miss Maisie Bookhardt, State Department of Education, secretary.

CAN YOU PROVE YOU WERE BORN?

By A. B. Fennell

This may come as a surprise, but if you are over 35 and were born anywhere in South Carolina except in Charleston County, you may encounter considerable difficulty in proving that you were ever born at all.

Recently, we had occasion to obtain some birth certificates for a friend, and while visiting the Bureau of Vital Statistics of the State Board of Health we started nosing around. The more we looked, the more we were amazed at the work of the Bureau and we discovered that vital statistics encompass far more than the mere keeping of birth and death records.

The Bureau was established January 1, 1915. Before that time there was no state law requiring that birth be reported. Charleston however, had required registration of births since 1877 and had registered deaths since 1921. So, if you were born anywhere in South Carolina except Charleston prior to January 1, 1915, the chances are that your birth was not registered and may be hard to prove.

Many of us, of course, may never need birth certificates, but there are many who will.

If you plan to travel abroad, a birth certificate is necessary before you can obtain a passport. Virtually all veterans need birth certificates, either for themselves or their children, when presenting claims for government benefits. Birth certificates may be necessary also in the settling of estates, and children entering school for the first time must have their birth records verified. This, by the way, is a doubled weapon. It keeps the kids out of school until they become six years old—then keeps them in school until they reach 16.

Birth certificates are indexed under the surname of the father and the maiden name of the mother. This simplifies matters where there have been divorces, or where the mother has married again after the death of her first husband. This cross index will probably prove even more valuable now that South Carolina has a divorce law.

Dr. Ben F. Wyman, State Health Officer, is registrar of the Bureau of Vital Statistics. He was not in the office the day we paid our visit, but T. P. Lesesne, assistant registrar, was there and became downright enthusiastic when he started discussing the work of the Bureau.

Mr. Lesesne pointed out that the work of the Bureau wasn't just the handling of dry statistics and records. There is plenty of human interest in those files and in the every day happenings around the office.

The steady decrease in disease and the better health of the State can be traced in large measure to the work of the Bureau. Malaria, for example, was once a scourge in this State. This was shown by vital statistics records and the Board of Health immediately set about eradicating mosquitoes, carriers of the disease. The death rate from malaria has been reduced from 26 per 100,000 population to two per 100,000. Statistics furnished by the Bureau have been a determining factor in the campaign against venereal disease and other infectious ailments.

Location of birth certificates sometimes taxes the ingenuity of the Bureau staff. Not long ago, a blind citizen applied for birth certificates for his five children. A search of the files revealed a record of but one child. The man insisted that he had given the correct dates and the correct maiden name of his wife.

Finally, after lengthy questioning, it developed that his wife had been married previously and that several of the children were fathered by him during her first marriage. Then the Bureau was able to locate the certificates in a matter of a few minutes. That is just one case. Similar ones bob up every day. Parents sometimes change their minds as to the names of their children after births are recorded and this requires some straightening out.

If you find that your birth has never been recorded and you want to get the records straight, there are several procedures which will accomplish the purpose. Usually, affidavits from the parents and two disinterested parties who have knowledge of the birth are sufficient. Baptismal records, or church records, may be presented as proof. All this is handled by the clerk of court in the county of birth.

But the work of the Bureau isn't all dry records and statistics. There are plenty of humorous, exciting and, at times, pathetic incidents.

Names tacked onto children sometimes cause wonder. For example, one set of twins was named Esso and Essolene after well known brands of gasoline. Don't ask us why. Perhaps pappy worked for Standard Oil . . . or perhaps mother figured the kids would set the world on fire.

Another mother named her child Shots. The reason? Well, for many years she had wanted a child, but due to venereal disease had been unable to fulfill her dream. Then she started taking treatment from the county health clinic. The treatment consisted of injections . . . or shots. So, when the child arrived, what was more natural than that it be named in honor of the shots which had made its birth possible?

Business and school planning, among other things, depend on figures obtained from the Bureau of Vital Statistics. School authorities can tell you now just what to expect in the way of school population four years from now when the current two-year-old crop enters school for the first time. Business firms plan advertising and sales campaigns on the basis of population figures furnished by the Bureau.

One interesting fact we ran up on concerned the comparative ratio of white and Negro births in South Carolina. Up to 1941, Negro births exceeded white births in the State. Since that time white births have increased at a greater rate. In 1938, there were 19,508 white children born as compared to 20,554 Negro. In 1941, there were 22,585 white as compared to 21,901 Negro. But in 1947, there were 33,800 white compared to 25,417 Negro.

Another is the growing tendency of prospective parents to call the doctor rather than depend on midwives or others for assistance. In 1937, doctors were in attendance at 17,297 white births. Midwives attended 2,166. But in 1947, doctors attended 33,097 white births as compared to 671 for midwives. Doctors attended but 3,644 Negro births in 1937 as compared to 16,858 by midwives. The figures showed that in 1947 midwives attended approximately the same number of births, 16,112, but the number attended by physicians had almost trebled at 9,212, all of which shows a better realization of the necessity of giving new South Carolinians a better start in life and assures a more healthful state.

Getting back to birth certificates for a moment, you will be interested to know that copies of birth certificates on file may be obtained for 50 cents. Veterans or their dependents may obtain copies of their own or their children's birth certificates at no cost.

Yes, the Bureau of Vital Statistics is performing a vital service.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

REPORT OF THE MEETING OF THE WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

The twenty-sixth annual meeting of the Woman's Auxiliary to the American Medical Association was held at Atlantic City, June 6-10, 1949. It was the largest meeting the Auxiliary has ever held, with 1583 women registered. There are 49,000 Auxiliary members in the United States. Of course all those who registered did not attend the meetings, but those who did were a group of capable, enthusiastic and inspiring women who are doing a wonderful and necessary work.

The headquarters were at Chalfonte-Haddon Hall. This is a hotel which lends itself very well to such a large meeting. Everything possible was done to make the meeting a success and our stay in Atlantic City a happy one. The local committee on convention arrangements deserves a great deal of praise for an excellent job. A very excellent program was planned and I am sorry more of our delegates could not have been there to enjoy it.

Not arriving in Atlantic City until Tuesday noon I missed the morning session when reports of officers and committee chairmen were given, also the luncheon when the guest speakers were Miss Leone Baxter, and Mr. Clem Whitaker directors of the American Medical Association National Education Campaign. These folks are doing a wonderful job in the planning of the campaign against compulsory health insurance for the American Medical Association. This is a campaign for the American People; an affirmative campaign for sound development in American economy; for the freedom of living. Socialized medicine would be a wedge towards total socialization and no American citizen wants that. The Woman's Auxiliaries to the county and state medical societies will be able to carry a big share of the load.

Each Auxiliary member should know the provisions of the Murray-Dingle bill and its possible effect upon American medicine. There is a problem to be sure but compulsory insurance is not the answer. The American Medical Association plan for a solution is voluntary health insurance along with other factors. We Auxiliary members must talk to our friends, seize every opportunity of having facts presented to women's clubs and distribute literature on the subject.

Tuesday afternoon there were some round table discussions on Hygeia, Legislation, Program and Public Relations. I chose legislation, that being a very important part of Auxiliary work right now. And it was most interesting to hear what women are doing all over the country.

The general session opened at 9 A. M. Wednesday morning with the president, Mrs. Luther H. Kice, presiding. About three hundred Auxiliary members were present. "In Memoriam", presented by Mrs. Neil Woodward of Oklahoma City was beautifully and most impressively done in memory of three past presidents, Mrs. Franklin Stuart Gengenback, 1926-27; Mrs. James Blake, 1933-34; and Mrs. Robert Tomlinson, 1934-35 and all Auxiliary members who have passed on this year.

At this session the reports of State Presidents were given and that is always one of the most interesting

parts of the meeting. All but three states responded and that is a record. Several new state Auxiliaries have been added this year, and many new members. It would be impossible to tell what each Auxiliary is doing, but their programs are broad and they are enthusiastically planning all kinds of health activities such as health days, school health programs, (and these include a wide selection of activities, according to what is most suitable for each location), radio broadcasts, nurse recruitment and most important of all right now the campaign against compulsory health insurance. The Auxiliaries are using various projects to combat the plan of state medicine, in fact some have planned programs to study plans for voluntary health insurance. These reports were really inspiring and prove that doctors' wives are each year becoming more interested in Auxiliary work.

We were encouraged to increase our subscriptions to the Bulletin. Some of the Auxiliaries reported 100% subscriptions. It is the one way we have of keeping up with all the things the National Board is doing and contains worlds of information we should each one of us have.

A representative from CARE made a request for books to be sent to medical students overseas. He suggested that such material would be good tools for reconstruction and food for the mind. They want technical, medical and professional books in English.

At the luncheon on Wednesday the guests of honor were President of the American Medical Association, Dr. R. L. Sensenb; President-elect, Dr. Earnest E. Irons; Chairman of the Board of Trustees, Dr. Elmer L. Henderson; Treasurer, Dr. J. J. Moore; Secretary and General Manager, Dr. George F. Lull; and members of the Advisory Council to the A. M. A. Mrs. Frank N. Haggard of Texas was toastmistress, and in her very charming manner introduced each guest and asked them to make a few remarks.

At the afternoon session the report of the nominating committee was read and new officers were elected. The president, Mrs. Luther H. Kice, presented the gavel to Mrs. David B. Allman of Atlantic City who has been president-elect this year. Mrs. Allman is a very attractive person and very capable and has been well trained this past year for her new job, so I am sure she will carry on the excellent work which is being done and the organization will go forward to greater accomplishments. Mrs. Kice has served the Auxiliary well. The membership has increased and much has been accomplished under her able, conscientious, efficient and dynamic leadership. Mrs. Arthur A. Herold of Shreveport, La. is our new President-elect.

I do wish more of our Auxiliary members would try to go to these meetings as the inspiration you would receive would make each one of us better Auxiliary members in South Carolina. I think this statement of Mrs. Luther H. Kice is a fitting thought to leave with you:

"Our program is charted for us. Our sights are raised to a high level. Our goal is to help the medical profession bring to our fellow Americans the finest in health and medical care. This we can accomplish only if we acknowledge our duties, realize our potential strength as a medium of truth, and pledge

ourselves to carry out our obligation to help in this most critical time. If we were to do anything less, we should not be worthy of our position."

Mrs. J. Warren White, Delegate

GREENVILLE BEGINS NEW YEAR'S WORK

The first meeting of the Auxiliary year was held on June sixth at General Hospital with quite a large group in attendance. The highlight of this meeting was a talk by Mr. Haythorn, superintendent of General Hospital, in which he outlined some of the needs of the various departments of the hospital. Certain projects were adopted and plans formulated for carrying out same.

First, a large assortment of lovely and entertaining toys were collected and presented to the children in Children's Ward of the hospital. The occasion re-

minded one of Christmas in all its glory. It not only brought great joy and happiness to the little ones, but also filled our hearts with inspiration for further activities.

At the present time we are in the process of making one hundred gowns for the nursery. As soon as these garments have been completed, we propose to direct our efforts toward making the rooms in the nurses' home more attractive and livable. The walls will be painted and the windows and beds provided with new draw curtains and spreads. This project is one which we all will enjoy tremendously.

Among our plans for the future is a benefit bridge to be held in October for the purpose of procuring funds for future activities. Each member of the Auxiliary is most enthusiastic and cooperative in anything our president wishes to undertake.

NEWS ITEMS

On May 17, 1949 the meeting of the South Carolina Chapter of the American Academy of General Practice was held at Myrtle Beach.

At this time new officers were elected and the outgoing officers were complimented on their activities of the past year. During the past year they arranged the inclusion of their state chapter into the national organization and sent delegates to the meeting of the American Academy of General Practice in Cincinnati.

The outgoing officers were: Dr. Robert Leonard, Spartanburg—President; Dr. Charles N. Wyatt, Greenville—Secretary; Dr. Thomas L. Glennon, Denmark—Treasurer. The new officers are: Dr. Henry F. Hall, Columbia—President; Dr. Hervey W. Mead, Columbia—Secretary-Treasurer; Dr. Robert Leonard, Spartanburg—Credentials Committee Chairman.

At present an active campaign to increase membership is under way. It is hoped that a large number of general practitioners will be able to attend the scientific and business meeting to be held in Columbia this fall.

Dr. R. Kyle Brown of Greenville was re-elected as Governor of the American College of Chest Physicians for the State of South Carolina at the Fifteenth Annual Meeting held in Atlantic City, New Jersey, June 2-5, 1949. Dr. Brown's term will extend over a period of three years. Dr. James W. Fouche of Columbia, received his Fellowship Certificate at the Convocation held at the Ambassador Hotel, Atlantic City, on June 4.

Dr. A. J. Goforth is now associated with Dr. J. W. Jervey in Greenville. His practice will be limited to otolaryngology.

Dr. Sam G. Lowe, Jr. has opened offices in Rock Hill for the practice of pediatrics.

Dr. Kenneth Lawrence has joined Dr. Rowland Zeigler of Florence in the practice of obstetrics and gynecology.

Dr. John K. Webb is now practicing general surgery in Greenville.

Dr. E. Alex Heise has returned to Sumter to resume work as director of the County Health Department. Dr. Heise has been in Atlanta for the past year as director of the Southeastern area of the Red Cross.

Dr. Robert B. Taft, Charleston radiologist, has accepted an appointment as medical consultant for the Oak Ridge Institute of Nuclear studies.

Dr. Homer S. Parnell, Jr., has opened offices in Greenville, his practice to be limited to general surgery.

The South Carolina Surgical Society held a meeting in Charleston on June 23rd at which time the following officers were elected to preside over this new organization: Dr. George Bunch, President; Dr. Edward Parker, Vice President; Dr. William C. Cantey, Secretary and Treasurer. Membership is limited to the South Carolina physicians certified by the American Board of Surgery. The next meeting of the Society will be held in Columbia next spring.

Dr. James M. Holman has opened offices in Charleston where his practice will be limited to diseases of the ear, nose and throat.

Dr. and Mrs. Henry Herbert of Florence have announced the birth of a son, Henry Williams Herbert, Jr., May 14.

Dr. William Johnson has become associated with Dr. W. K. Rogers of Loris, where he is engaged in the general practice of medicine.

Dr. and Mrs. George Smith of Florence are receiving congratulations upon the birth of a daughter (their fourth), Martha Elizabeth, June 24.

Dr. B. C. McLawhorn is now practicing medicine at Fountain Inn.

Dr. William H. Bridgers of Columbia has successfully completed the examinations given by the American Board of Neurological Surgery. Dr. Bridgers is one of the few diplomates of this Board in the Southeast.

A. M. A. Assessments received from April 25 to June 25.

Charleston	Manning
Banov, Leon, Sr.	Bozard, A. C.
Buist, A. J., Jr.	Harvin, W. S.
Coleman, Ralph R.	King, J. H.
Murdoch, John H., Jr.	Orangeburg
Remsen, D. B.	Gressette, J. H.
Cheraw	Pageland
Funderburk, I. S.	Fulenwider, J. O.
Harrison, J. P.	Griggs, D. C.
Hodge, J. E.	Pickens
Hook, M. W.	Ballard, C. E.
Chesterfield	Cannon, E. G.
Perry, Wm. L.	Moore, P. J.
Wiley, W. R.	Valley, T. P.
Columbia	Ruby
Alion, J. J.	Newsom, R. M.
Chappell, B. S.	Seneca
Davis, L. C.	Mays, L. E.
Dotterer, T. D.	Orr, Jas. E.
Green, Jas. T.	Webb, J. N.
Hall, Wm. S.	Wells, H. H.
Lemmon, C. J., Jr.	Spartanburg
MacInnis, Katherine B.	Phifer, I. A.
Mathias, M. L.	Way, Roger A.
McDaniel, G. E.	State Park
Wheeler, Paul C.	Battle, G. C.
Conway	Summerton
Marshall, Jas. M.	Howle, M. G.
Sasser, Jas. A.	Sumter
Easley	Baker, C. R. F.
Cutchin, J. H.	Bell, Jas. E., Jr.
Jameson, J. H.	Bultman, R. B.
Jeanes, R. P.	Calder, A. B.
Pepper, Jas. C.	Chandler, Jas. J.
Poole, L. R.	Cone, Wallis D.
Tripp, C. H.	Eaddy, N. O.
Fair Play	Harvin, John R.
Mays, Wm. C.	Hewitt, Ragsdale
Florence	Mood, H. A.
Hood, E. C.	Kneeland, M. L.
Stokes, J. H.	Parrish, M. E.
Fort Mill	Rhame, J. M.
Elliott, J. B.	Snyder, W. J., Jr.
Greenville	Stuckey, W. A.
Murray, John G.	Walker, R. M.
Greenwood	White, Charles H.
Harrison, John D.	Winter, D. O.
Tucker, E. W.	Union
Turner, W. P., Jr.	Hope, H. P.
Turner, W. P., Sr.	Walhalla
Lake City	Booker, John P.
Singletary, Herman	Davis, John T.
Langley	Westminster
Royal, H. G.	Shuler, E. L.
Leesville	Strickland, W. A.
Ellis, E. B.	Also paid
Liberty	Mims, J. Lloyd,
Kitchen, J. W.	Arlington, Va.

DEATHS

REAMER LORENZO COCKFIELD

Dr. R. L. Cockfield, 65, popular physician of Lake City, died at a Florence hospital on July 7, following a heart attack.

A native of Florence County, Dr. Cockfield received his education at Welsh Neck High School, the University of the South, Sewanee, and the Medical

College of the State of South Carolina. Following post-graduate work at Columbia University, New York, he opened an office in Johnsonville, then moved to Lake City in 1925 where he continued to practice until his death.

Dr. Cockfield is survived by four daughters and a foster son, Dr. W. H. Thomas of Greenville.

**PROGRAM
OF THE
FOURTEENTH ANNUAL
PIEDMONT POST GRADUATE ASSEMBLY**

TUESDAY, SEPTEMBER 20, 1949

3:00 P. M.

"THE DIAGNOSIS OF PERIPHERAL VASCULAR DISEASES"

Dr. E. A. Hines, Jr. — Mayo Clinic — Rochester, Minn.

4:00 P. M.

"MANAGEMENT OF PROLONGED LABOR"

Dr. John R. McCain — Atlanta, Ga.

5:00 P. M.

Rose E. Ramer Lecture — "CANCER OF THE FEMALE GENITAL ORGANS"

Dr. Calvin B. Stewart — Steiner Clinic — Atlanta, Ga.

7:00 P. M.

BANQUET — ANDERSON COUNTY MEMORIAL HOSPITAL CAFETERIA

8:00 P. M.

GREETINGS

Dr. Roderick MacDonald — President South Carolina Medical Association

Rock Hill, S. C.

8:15 P. M.

"THE PLACE OF THE NEWER ANTIBIOTICS IN THE PRACTICE OF MEDICINE"

Dr. Paul B. Beeson, Professor of Medicine — Emory University — Atlanta, Ga.

Our schedule should permit a fifteen minute question and answer period following each of the above papers.

WEDNESDAY, SEPTEMBER 21, 1949

3:00 P. M.

Panel Discussion—"CHEST INJURIES"—"BURNS AND SHOCK"—"FRACTURES"

Dr. Robert Major; Dr. J. H. Sherman; Dr. Peter B. Wright—University of Georgia
School of Medicine — Augusta, Ga.

5:00 P. M.

"PREMATURE SEPARATION OF THE NORMALLY SITUATED PLACENTA"

Dr. John R. McCain — Atlanta, Ga.

7:00 P. M.

BANQUET—ANDERSON COUNTY MEMORIAL HOSPITAL CAFETERIA

8:00 P. M.

"ADVANCEMENT IN THE TREATMENT OF CARDIO VASCULAR DISEASES"

Dr. E. A. Hines, Jr. — Mayo Clinic — Rochester, Minn.

8:45 P. M.

"MANAGEMENT OF INJURY TO THE URINARY TRACT"

Dr. Clyde F. Bowie — Anderson, S. C.

South Carolina Medical Association

1949-1950

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W. R. Tuten, M.D.	Fairfax	President-Elect
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The Journal

of the

South Carolina Medical Association

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NUMBER 9

The Doctor In His Relationship To His Community

W. L. PRESSLY, M. D.*
Due West, S. C.

I am here today not in a personal or individual but rather in a representative capacity. In accepting the award from the American Medical Association, I stated that I did not regard it as that which had come to me personally, but to me as the representative of the 130,000 General Practitioners. To be the representative, even for a short time, of this company of splendid men gives one a feeling of great responsibility. For, while I personally am not important, this group which for a brief period I represent, is important. It is an integral and essential part of the Medical Fraternity and from year to year renders a conspicuous service in its ministry to suffering humanity.

Frequently in this day we are reminded that the horse-and-buggy days are gone, and that the old-fashioned country doctor exists only as a memory. In one sense this is true. Many things that characterized the life of the horse-and-buggy doctor have departed with the horse and buggy. Life with us today moves too rapidly for the doctor to spend all day with one patient and all night with another—in each case serving as both doctor and nurse. Likewise good roads, modern communications, modern conveniences, and easy access to well equipped hospitals have made it unnecessary “to perform operations by candlelight and under the crude conditions of country homes where almost any case was an emergency.” In like manner our modern educational system has brought the advantages of High School and College Education to vast multitudes. Hence, the doctor is no longer one of the few educated men in the community and, consequently, he is not expected to counsel and advise along as many lines as formerly. In these and other respects much that characterized the ministry of the country doctor has passed.

However, let us not think that all that characterized

his life has passed or should pass. Many things that were strikingly manifest in his practice we today should seek diligently to preserve. In an editorial in the Halifax Gazette regarding the late Dr. I. K. Briggs of South Boston, Va., described as “One of the few country doctors left,” some of the abiding things we need to cultivate are made clear. I quote:

“Dr. I. K. Briggs, a servant of the people, passed on to eternal sleep Tuesday. The man and his little black bag, moving silently and unpretentiously among his people, healing wounds and mending broken bodies, bringing health and hope to thousands—he was accepted as much a part of this community as the time-worn landmarks that identify this community as home.

“He was more than just a doctor. Ask anyone of thousands about that. Neither storm nor darkness deterred him from calling on those who needed him. Nor did his personal comfort and health count for much when it came to fulfilling the mission to which he had dedicated his life. He was literally worn out before his time because others needed him more than did the demands of his own well-being. If there was sickness or injury, Dr. Briggs was ever ready to administer the fine knowledge he possessed of the curative powers of medicine and surgery.

“His life and nearly all of his energy was dedicated to the ministry of healing the sick and wounded. Other things were trivialities to him. There were so many who needed him and he could not escape a deep sense of responsibility to them. How seldom does one find such consecration to duty. Yet, withal, he was a lovable person.”

Here, as we see, this editor makes emphatic, certain abiding characteristics. His interest in and love for the people among whom he lived and to whom he ministered; his unselfish, self-sacrificing devotion to duty, ever placing another's needs above the demands of his own well-being; his recognition of the claims of obligation and responsibility — these were the thoughts uppermost in the minds of men long after “the sunny beaches and the tantalizing blue waters of

* Recipient of the annual (1948-49) General Practitioner's award of the American Medical Association.

(Paper presented at Annual Meeting, S. C. Medical Association, May 17, 1949.)

the great beyond" had beckoned Dr. Briggs.

These words "obligation" and "responsibility" should never be lightly pushed aside. They apply to the community in its relation to the doctor as well as to the doctor in his relation to the community.

The community discharges its obligation in part, at least, by the special privileges granted to the doctor. The doctor is allowed to practice in a manner he believes to be wise, without restraint of direction. His statement as to the cause of death is accepted without question. A simple statement from him that a juror, a witness, or even the defendant is too sick to continue, is sufficient to postpone or even stop a trial. He is not subject to jury duty, and he is not criticized if, instead of going to church, he sits in the staff room and chats with his colleagues during the church hour. During gasoline rationing, he set his own figure as to his needs, and he was not too harshly criticized if he fudged a little and used his car for a little unnecessary pleasure driving.

Too, the community gives to the doctor its confidence and respect. He is entrusted with the most intimate details of the personal and family life of his patients. Indeed, the most sacred interests of their lives are entrusted to him. They respect his judgment and listen with approval to his opinions. His fellow citizens are hard to convince that he is not the kind of man they have come to expect in the profession of medicine. It has come to be and it still continues that these privileges, this respect and indulgence are recognized obligations of the community to its doctors.

Then, there are other privileges which are not so widely accepted by the layman but are becoming more universally demanded by the profession. These have to do with the matter of charges for services, hours of work, vacations and choice of patients. These have to do also with educational and cultural opportunities and with physical equipment for the widest and largest use of their technical skills. The well-trained, conscientious doctor may reasonably expect of his clientele that they realize he is not selling commodities, but is dispensing to rich and poor alike a highly specialized service. In order to render this service to the poor in the most effective way it is necessary that there be adequate and accessible hospitals. These are privileges which have to do with the material aspect of the business side of medicine. And, while essential, we must confess that they tend to slip in between the doctor and his one time adulating public.

As one of my doctor friends expressed it, "there is a great danger because of the doctor becoming so economic conscious, so intent on providing well for his family both before and after his death, so determined not to be taken in by the dead-beat, so careful to guard his health by adequate unbroken sleep, by regular afternoons off, by periodic vacations, and ultimately to postpone an early death by that great

destroyer of physicians, coronary disease, that he ceases to be a servant of the people to be turned to in time of trouble and becomes instead, a public utility, without government supervision or regulation. And when that time comes, the doctor relinquishes his eminence, gives up his hero worship, and comes to be grumbled at and against, just as is the transportation system or the telephone service."

Hence, we should be honest with ourselves and with one another as we face the truth that the doctor, in exchange for his privileges and his adoration must, if he would retain this attitude peculiar to his profession, recognize that he too has obligations of a very definite character to his community.

No doubt, it was with this idea in mind that the 2nd annual meeting of the World Medical Association, held in Geneva in September 1948, sought to revive the old oath of Hippocrates. This old oath has been somewhat revised and now has the name of Geneva associated with it. It is to be made available in the appropriate languages to all the doctors of the world. Furthermore, it is believed that its acceptance by the oncoming generations of doctors in every land will do much to raise the standard of medicine throughout the world. Here is the ten point oath which is administered at the time one is being admitted as a member of the Medical Profession:

1. I solemnly pledge myself to consecrate my life to the service of humanity.
 2. I will give to my teachers the respect and gratitude which is their due.
 3. I will practice my profession with conscience and dignity.
 4. The health of my patient will be my first consideration.
 5. I will respect the secrets which are confided in me.
 6. I will maintain by all the means in my power, the honor and noble traditions of the medical profession.
 7. My colleagues will be my brothers.
 8. I will not permit considerations of religion, nationality, race, party, politics or social standing to intervene between my duty and my patient.
 9. I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.
 10. I make these promises solemnly, freely and upon my honor.
- (Quoted from the first issue of the "World Medical Association Bulletin.")

This is a very searching oath. By it very definite obligations are imposed. By it the Medical Profession is challenged to set for itself a very high standard. Guided by its principles the doctors would be

strengthened in fulfilling the obligations that rest ever upon him.

But the obligations of a doctor are not confined wholly to those in line with his profession. He is also a citizen. He belongs to the best educated, the best trained group, in any community. He has been trained to leadership, to think logically, to make quick decisions based on observation and logical deduction. Such a one owes it to his community to use those powers in community betterment in other realms besides that of medical care. And as the doctor grows older, having left behind the long years of training in school, in hospital and in early practice; having so

served through the packed and crowded years of professional maturity as to win the confidence and esteem of his fellow citizens, he is better able to make his influence count in the things that strengthen and build the community. Released from some of the duties that bound him, he should give more of his time, his energy and his ability to becoming a great citizen and thereby help to make of his hometown a great community. He who is permitted so to do need never fear the changing attitude of the people toward their doctors. Best of all he will find his life filled with those "durable satisfactions" which are the by-products of a work well done.

Cancer Of Uterus

J. R. YOUNG, M. D.
Anderson, S. C.

This talk on cancer of uterus does not profess to be a discussion of that subject on conventional lines. It is rather a partial report by the Chairman of Cancer Commission on the progress that is being made in our state by the Cancer Division of State Board of Health in treating cancer of the uterus. I am making this talk at the scientific session rather than before the House of Delegates because I believe the subject merits our very careful consideration. In making this talk I hope to accomplish the following:

1. To impress on our minds that in our state cancer of the uterus is the most common cause of cancer death in the female. For the five year period 1943-1947 there were 1193 deaths from this cause, an average of 238 each year. During the three day session of this medical meeting two women in our state will die from cancer of the womb.

2. I want the members of this association to understand fully the handicap we are taking when we accept for treatment the advanced cases of cancer of the uterus that we are now seeing. So long have we thought of cancer of the uterus in terms of foul discharge, uterine bleeding, pain, secondary anemia, weight loss, etc. that we forget that none of these is a symptom of early cancer. The handicap that the surgeon has in treating such a case is analogous to that he has in treating acute appendicitis after the appendix has ruptured; or in treating pulmonary tuberculosis after cavitation. Just as the mortality of acute appendicitis and tuberculosis has been brought down from a distressingly high level to a low level by selling the medical profession and the public on the necessity of early diagnosis and prompt treatment, so it now appears, must the medical profession and the public be sold on the absolute necessity of early

diagnosis and prompt treatment of all types of cancer. The weapons we now have—radium, x-ray and surgery are effective only if applied reasonably early.

3. The third and most important reason I have for presenting this talk is to impress on our minds, particularly upon the minds of us older men, the significance and implications of the phrases, carcinoma in situ, epithelial carcinoma and non invasive carcinoma. These expressions, which are comparatively new in medical writings, emphasize the fact that for a time cancer is a purely local disease. According to the opinion of Pund and others cancer may remain non invasive for several years, perhaps three to ten. It becomes at once apparent that the opportune time to diagnose and treat cancer of the cervix is during this period that the disease remains local. The diagnosis cannot be made in this stage of the disease by vaginal examination alone. Such an examination may reveal an eroded cervix but more apt than not such a cervix will not be malignant. The overwhelming weight of evidence, accumulated during the past few years supports the claims of Papanicolaou of New York, Ayers of Montreal and Seibels of Columbia and others that the study of the cervical and vaginal smears, Cytology, offers a most valuable aid in making the diagnosis of early uterine cancer. My own experience in the study of the cervical and vaginal smears as an aid in the diagnosis of early uterine cancer is quite limited but from a rather close study of recent medical writings on this subject I am convinced that the wide spread use of this procedure in the offices of doctors throughout the state could be a valuable aid in the diagnosis of early uterine cancer. Few of the doctors in our state have either the time or special training for staining and appraising such slides, so we will have to make arrangements to have such slides stained and examined by someone trained in this line of work. I understand several laboratories in our state are doing

some of this work. For several years Seibels Laboratory in Columbia has been rendering this service. Possibly if the volume of this work increases as it should we may be able to have our State Board add this service to that they are already doing. All the examining doctor would need to do would be to secure a smear from the cervix and vagina and send the dried, unstained specimen to someone trained in the study and interpretation of such slides. All advocates of this test agree that in a case that is positive further proof should be sought to confirm the diagnosis. If cancer of the fundus is suspected a diagnostic curettage should be done. If cancer of the cervix is suspected a cervical biopsy should be done. The use of this test as a screening procedure is certainly harmless and if every positive case is checked by biopsy we see no objection to the wide use of this procedure as an aid in making an earlier diagnosis of cancer of the uterus.

It seems to be the consensus of opinion of those most familiar with this problem that any further improvement in the management of this disease must come from earlier recognition and treatment. Galen made a similar observation about 2000 years ago when he said "earlier diagnosis is necessary if we are to cure cancer." But during the hundreds of years since Galen's day the only method of making a diagnosis was the appraisal of uterine dysfunction and examination of a new growth that had attained some size. We now know that when a new growth has developed enough to cause dysfunction, abnormal bleeding, leukorrhea, etc. it is all too often no longer an early lesion. Within the present decade vaginal and cervical cytology has developed to the degree that it should now be possible by the wide spread use of this procedure on an office basis to find an increasing number of early uterine cancers.

It is my firm belief that the members of this association could very materially reduce the mortality of uterine cancer in our state by the wide spread adoption of the vaginal and cervical smear as an office procedure. The large proportion of negative reports should not deter the doctor from making this test a routine office procedure because he will in time certainly find evidence of early cancer of the uterus which after it is confirmed by biopsy should receive prompt treatment by surgery or radiation.

In our state we have no data as to incidence of uterine cancer. In Connecticut and New York State, exclusive of New York City, and in ten urban areas studied by H. F. Dorn of U.S.P.H.S. ten years ago the incidence of uterine cancer is given as varying from 40 to 50 per 100,000 population. If this incidence rate prevails in South Carolina then some four hundred women are developing uterine cancer each year. The best that the medical profession of our state can offer these patients is a good deal less than a 50-50 chance. And none of us is satisfied with such poor re-

sults but hitherto we have not known anything we could do about it. From a careful study of recent medical literature and from talking with others, who have had considerable experience with cervical and vaginal cytology as a diagnostic aid, it is my opinion that the mortality of uterine cancer can be very materially reduced during the next decade if the doctors throughout the state will begin at once the practice of getting cervical smears in their female office patients.

Figure 1

1946

Cancer Deaths in United States	
All Sites	182,005
Cancer Uterus	17,205
9.5% all Cancer Deaths	
Death rate per 100,000 — 24.3%	

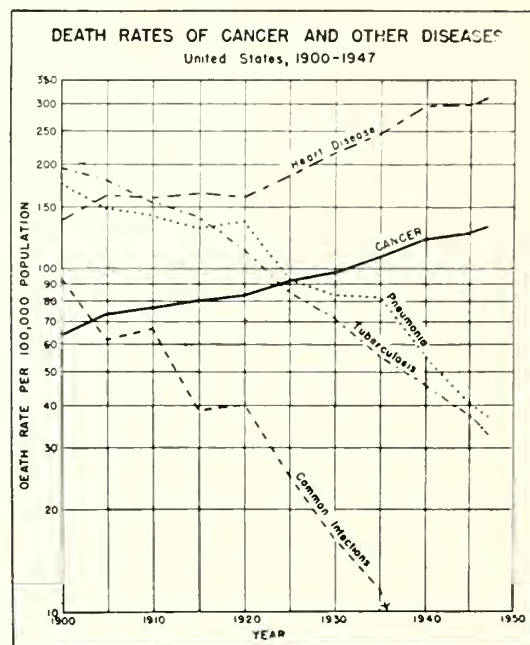


Figure 2

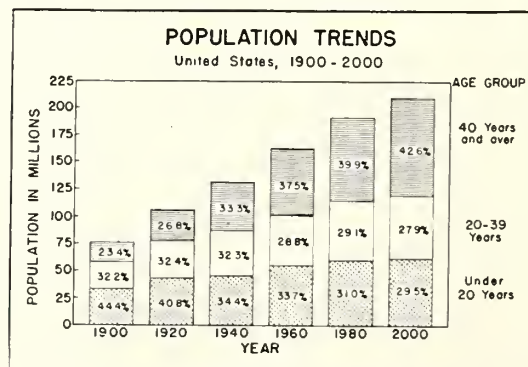


Figure 3

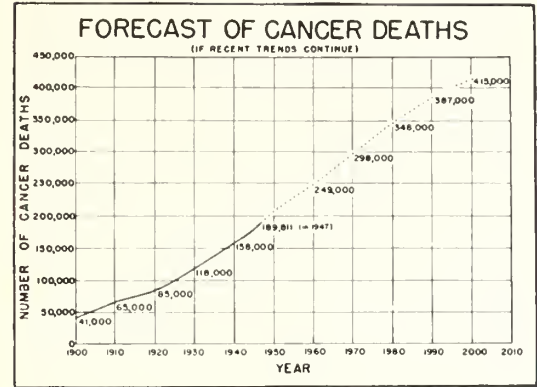


Figure 4

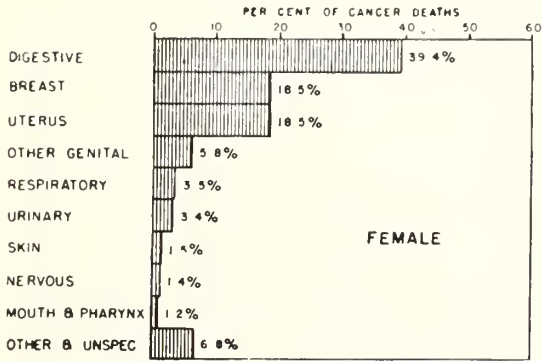


Figure 5

FEMALE CANCER DEATH RATES* BY SITE
United States, 1933-1946

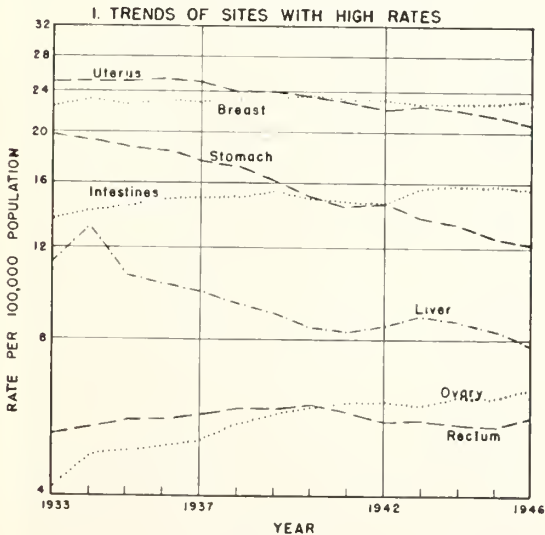


Figure 6

Figure 7

Decade 1937-1947

Total Deaths in S. C.	185,167
Deaths from Cancer in S. C.	11,491
Cancer Deaths about 6% all Deaths.	

Figure 8

Cancer Death Rate

per 100,000 population

United States	120
South Carolina	90

Figure 9

1945-1947

Deaths in South Carolina

Total	50,335
Total from Cancer	3,931
Cancer deaths about 8% all deaths.	

Cancer Uterus deaths about 17% all deaths from Cancer.

Figure 10

Cancer Clinics of South Carolina

1941-1947

Patients treated	4467
Deaths	970

Death rate about 22%

Figure 11

Cancer Clinic

Anderson County Memorial Hospital

1940-1948

Cancer Cervix	105
Cancer Fundus	17

Total	122
-------	-----

Figure 12

Cancer Uterus

1940-1948

Anderson County Memorial Hospital

Age data

20-29	8
30-39	15
40-49	29
50-59	34
60-69	30
70-79	6

Total	122
-------	-----

Figure 13

Cancer Cervix

Anderson County Memorial Hospital

1940-1948

Patients treated	105
Symptom free 5 to 8 years	10
Improved, still under treatment	40
Unimproved—terminal care	7
Deaths	37
Unable to locate, moved, etc.	11

Figure 14	Symptom free 5 to 8 years	6
Cancer Fundus	Improved, still under treatment	5
Anderson County Memorial Hospital	Deaths	3
1940-1948	Unable to locate, moved, etc.	3
Patients treated	Total	17

Preventive Immunizations Of Infancy And Early Childhood

J. I. WARING, M. D.
Charleston, S. C.

The subject of this paper is a hardy perennial whose blooming is perhaps justified by frequent improvements in products and techniques. While many vaccines and sera come and go, are publicized and forgotten, nevertheless there is a steady development of well established and effective procedures, and a steady reduction in those diseases against which we have effective agents.

For our purpose this paper proposes to consider only the more or less controllable diseases which interest us in South Carolina, and will mention only briefly the incidence and mortality of our more important communicable diseases, realizing that the figures for incidence are low because so many of our doctors, for reasons best known to themselves, fail to make the reports required by law and important in planning control measures.

The latest available figures (1946) show incidence as follows:

SOUTH CAROLINA — 1946		
	Cases	Deaths
"Influenza"	22,829	210
Measles	7,579	29
Whooping Cough	2,056	30
Scarlet Fever	303	0
Diphtheria	249	29
Typhoid	80	21
Typhus	71	11
Tetanus	10	9
Smallpox	0	0

The relative importance of these diseases may be based on relative mortality or relative morbidity, with the realization that in some instances our means for control by immunization are limited. Those for which we have reasonably adequate means might be considered separately.

Beginning with the most prevalent, it is unfortunate that practical trials with influenza vaccine have given rather disappointing results. The vaccines available include usually only two of the many strains, give but brief protection for perhaps a single season, and produce many mild reactions and the possibility of

sensitizing the recipients to the egg on which the vaccine is grown. In the face of a threatened epidemic, especially where the vaccine strain corresponds to the prevalent strain producing clinical disease, it may be used to advantage. A single dose, 1 cc, scaled down by age is usually sufficient to produce such immune response as is possible.

For measles we have no means of producing active immunity except by actual infection. Gamma globulin is quite valuable in modifying the disease and reducing complications, but has no value in treatment, yet apparently is used surprisingly often for this purpose. To be worthwhile it must be used within six days of a known exposure and given to children in doses from 0.5 to 2. cc according to the size of the patient. For adults large doses seem unavailing. Broadcast use in epidemics without knowledge of exposure is wasteful and of doubtful value. The material gives no reaction, no sensitizing, no permanent protection. Modified measles may be scarcely recognizable and the immunity status of the patient is often left in doubt.

Whooping Cough vaccine is still not as effective as could be desired. It produces more or less immunity in about 75% of children and is valuable chiefly in lightening and shortening cases and eliminating complications. The type of vaccine is constantly being improved. The age of administration is gradually being lowered, reactions lessened. It was long thought that protective antibodies could not be produced in young infants, among whom whooping cough produces its highest mortality. Recent work of Sako and others shows that agglutinins can be produced consistently when vaccine is started at one month and given in doses of 0.2 cc, 0.3 cc, 0.5 cc monthly (40 billion per cc). Sterile abscess occurs in 0.6% of the young babies. While abscess formation is never serious, it is psychologically bad. A booster dose is given eight months later, and the protection lasts somewhat over two years. The booster effect occurs in about ten days after administration of the single dose. Pertussis vaccine given at various ages under six months gave worthwhile protection as shown by the presence of antibodies in the blood, but protective levels were

(Read before S. C. Public Health Association, Myrtle Beach, S. C., May 30, 1949.)

achieved less frequently and lasted more briefly than those produced in children over six months. It has also been noted that the older children responded better to the booster dose.

Pertussis Vaccine (3 doses) produced the protective level of antibodies in the blood of

Newborns and infants under 6 months		Infants over 6 months
1 month later	54%	86%
3 months later	33%	82%
After booster		
1 year later	63%	92%

Perhaps the practical application of these figures is to start whooping cough vaccination at 3 months, thereby securing a fair percentage of protection by about 5 months, and to give a booster dose at 18 months. Reactions are no more severe in the earlier months than they are later.

A word should be said for the use of pertussis human immune serum or rabbit serum in prophylaxis and treatment of pertussis in young babies. Its expense is a drawback, but its effect is often life saving both in prevention and in treatment.

Diphtheria toxoid is one of our most effective weapons, producing in routine doses immunity that is long lasting, but often not permanent, in perhaps 95% of children. Reaction is rare.

Until recently, because of the prevalence of diphtheria in the general population, and the presence in the blood of nearly all mothers of antibodies gradually acquired by subclinical infections, we thought of young infants as immune to diphtheria. Now with diphtheria decreasing, it is found that about 40% of mothers are Schick positive, i. e., have no protection to pass on to their babies, who are consequently susceptible to diphtheria from birth. In South Carolina one tabulation showed that 15 to 20% of student nurses entering Roper Hospital were Schick positive, a rough indication of the immunity in our general population, or perhaps an indication of overabundant diphtheria in our midst. Those babies who do acquire antibodies from their mothers begin to lose the protection before the fourth month, by which time only one-third have a protective level. Thus early administration of diphtheria toxoid is advisable, even though one may be hesitant to incur the 2% of sterile abscesses which follow the injection in young infants in spite of precautions as to the use of deep intramuscular injection with dry syringe and needle. For wholesale use, such injection is unhandy.

Effect of Diphtheria Toxoid

Protective level of antitoxins produced by

	Initial Series	Booster
(1) Newborns	20%	70%
(2) Infants over 6 mos.	84%	95%

Disregarding the possibility of abscess, one might

then begin toxoid at 3 to 4 months with expectation of good result.

Tetanus toxoid has been well proven as a safe and successful producer of immunity, and has become in common use a sort of Siamese twin with diphtheria toxoid. Figures from the armed services are most convincing as to its value. Basic immunization may be given by two doses of alum precipitated toxoid at an early age, as response is good even in the first few months of life, and a booster dose a year or two later will give an additional protection lasting perhaps as long as five years. Where it is desirable after basic immunization to produce rapid increase in protection, the fluid toxoid is superior to the alum precipitated type. In order that production of sensitivity to horse serum may be avoided, antitoxin should be used only when toxoid has not been given or wound contamination is heavy.

Scarlet Fever has become with us a relatively mild disease, reasonably amenable to treatment with penicillin or sulfa compounds or the vis medicatrix naturae. Transitory active immunity can be produced by a series of 5 or 6 injections of toxin, which injections may be productive of considerable reaction. Routine use is of very questionable value and is not generally carried out.

The need for vaccination against typhus fever is considerable only in areas where the disease is endemic and not controlled by general public health measures. Vaccination is relatively free of reaction and relatively efficacious but for general use it does not seem necessary.

Typhoid, however, is still widespread enough to warrant vaccination in areas where it occurs, although there is increasing probability of decreasing need as sanitation progresses. It may be given to the very young in typhoid areas, even at one year or less, but where typhoid is comparatively uncommon, three years may be a good age, with small annual boosters to keep the protection alive. The intradermal method is satisfactory and much less liable to produce systemic reactions, both in the primary series and for boosters. The local reaction which appears in adults is relatively trifling in children. Recent work indicates that an interval longer than the usual week, perhaps as much as a month, may be preferred.

Smallpox vaccination in the minds of many people is only a nuisance required for entrance into school, and when our statistics show no cases of smallpox in the state, one might question the need for routine use. However, history shows so often that smallpox inevitably breaks out in a population not immunized, particularly in this day of rapid communication with all remote parts of the earth we should maintain our immunity lest we return to the early graves or pock-marked faces of our ancestors. Vaccination in the first few months of life is easy and effective, far less troublesome than in the preschool period. The multiple puncture method is best, and vaccination should

be repeated about every 5 or 6 years. As you all know, smallpox vaccine is the most difficult of all to handle and keep potent, and therefore one should be most skeptical of the existence of immunity in the unvaccinated until many vaccinations with various batches of vaccine have been attempted.

Now the practical part of these statements might be summarized this way—and perhaps this as an opening paragraph might have saved your time and ears.

Most of these diseases do their worst in very early life, and therefore early efforts at immunization are desirable.

Most of the agents used will produce some response even in newborns, but the response is uncertain and not as lasting as it is a little later on. Reactions, except for sterile abscesses, which will occur in 1 to 2% of young infants, are no more marked than at a later age. The theoretically desirable procedure of immunizing the mother for the sake of the baby has not proven sufficiently reliable to put to general use.

Because whooping cough is the most dangerous of these diseases for very young infants, we should start our vaccine as early as is practical, say at 3 or 4 months. If we wish to include diphtheria and tetanus at this time, we can put all three in one preparation, but it has been shown that many infants at 3 months still have enough inherited diphtheria antitoxin to interfere with the successful development of active immunity by the toxoid. We must choose between the desirability of early pertussis immunity and the possibility of poor response to diphtheria toxoid if we start the triple combination at 3 months. We might then use plain pertussis vaccine at 3 months and give diphtheria-tetanus later, or we might wait until 4 months and give all three together, a procedure which would reduce the doses from 5 to 3 without any increase in probability of reaction. In cost, the triple dose method would be cheaper. This then might be our schedule by which we may expect reasonably adequate protection against the 4 diseases about the eighth month, and renewal of protection at intervals frequent enough to keep a satisfactory level throughout early childhood.

SUGGESTED SCHEDULE OF IMMUNIZATION

3 months	4 months	5 months	6 months	12 months
Smallpox	Diphtheria	Diphtheria	Diphtheria	Sehick Test
	Tetanus	Tetanus	Tetanus	
	Pertussis	Pertussis	Pertussis	
	(Combined)	(Combined)	(Combined)	
1½ years	3 years	4 years	5 years	6 years
Diphtheria	Typhoid	Typhoid	Typhoid	Typhoid
Tetanus	(3 doses)	(1 dose)	(1 dose)	(1 dose)
Pertussis		Diphtheria		Diphtheria
(Combined)		Tetanus		Tetanus
		Pertussis		Pertussis
		(Combined)		(Combined)
				Smallpox

**TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION**

1949

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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SEPTEMBER, 1949

WILLIAM W. BOYD

In the passing of "Billy" Boyd our Association has lost one of its hardest workers and staunchest supporters. A leader in his community and in his medical district, a member of our Council for a number of years, he was ever zealous of his chosen profession and of the principles upon which it was founded. Endowed with a keen mind, a winsome personality, and sterling integrity, he was a man to be admired and loved. His place will be hard to fill but our Association is the better for his having lived, and we join with his family in Spartanburg and with his many friends throughout the state in honoring his memory.

BLUE SHIELD

Present indications point toward the establishment of a Medical Service (Blue Shield) Plan in our state within the immediate future. Dr. J. D. Guess and his committee have worked hard and faithfully and final touches are being given to the many details of the Plan. If all goes as anticipated, the Plan will be in operation before the year is out.

Believing that this is one of the most important ventures ever undertaken by our Association, we beg the support of every member in making the Plan a success. In no other way can we show more clearly and concretely our desire to serve the people of our state and to lead them down the road toward better medical care.

ANNUAL DIRECTORY

Our annual directory will soon be going to press. As in the past, it will contain the names of all members in good standing of our Association. And those who are in good standing are those who have paid their dues for the current year. We hope that this will be a gentle reminder for that small group who, for one reason or another, have failed to send in their 1949 dues.

A. M. A. EDUCATIONAL CAMPAIGN

Except to those who do not or will not see, the Educational Campaign of the A. M. A. has demonstrated its great value. Recent developments in Washington and the general thinking throughout the country show that the people of America are beginning to realize a federal system of medical care is not the type of thing which is best for this nation. And we are confident that, as time goes on, the revolt against any type of bureaucratic medical care will rise to such a pitch that it will be impossible for Mr. Truman, Mr. Ewing, or any other individual or group to thrust their plan for socialized medicine down the throat of the public.

To carry on this educational program costs money. Well over half of our members have contributed their \$25.00. To those who have not we say this—a fight is being waged, and successfully, to protect the voluntary system of medical care which you have known and which you cherish. The fight must be continued if the battle is to be won. Your money is needed. Send in your \$25.00 today.

TO OUR YOUNGER MEMBERS

The hot days of summer are gone, a touch of autumn is in the air, the school bells are ringing again, and the annual vacation is but a pleasant memory. It is time to rouse ourselves from that lethargy which hot weather brings and to get back to work. And there is much work to be done in our county and district societies and in our state association.

For some time we have felt that there were probably a number of the younger men in our Association who would like to participate more actively in its work and activities. That they do not have a part in what is going on is undoubtedly due to one of two things: (1) they do not know how to get into the work, (2) they feel that the older men are running things and that there is no place for them. Let us assure them that there is plenty of work for all and that their help is sorely desired.

Here are some of the fields in which a younger

member can cut his teeth on Association work: preparing case reports or abstracts for publication in the Journal, making talks before lay groups on the medical problems of the day, helping to work out plans for improving medical care in our rural areas, helping to evolve methods for improving the care of our indigent, helping to promote more widespread use of Blue Cross, Blue Shield, and commercial hospital and medical insurance, helping to improve our courses in post-graduate medical education, studying the problem of nurses and nursing care and trying to figure out some

method whereby we may secure more nurses, working out plans whereby the scientific sessions of our local, district, and state meetings will be more effective and interesting.

These are some of the things that are waiting to be done. If there is any younger, or older, member in the association who would like to help to tackle these problems, he is asked to communicate with Dr. Roderick Macdonald, our President, or with the Secretary, and make his intentions known. We will promise him that he will be given something to do.

REPORT OF THE AMERICAN ACADEMY OF PEDIATRICS STUDY OF CHILD HEALTH SERVICES IN SOUTH CAROLINA

Abstracted by
JOSEPH I. WARING, M. D.

FOREWORD

The survey reported here is one unit of a national survey conducted in all the states as the first step toward finding facts for the foundation of a broad program "to make available to all mothers and children of the United States all essential preventive, diagnostic and curative medical services of high quality which, used in cooperation with other services for children, will make this country an ideal place for children to grow into responsible citizens."

The need for such a program was worded by the American Pediatric Society in September 1944, and the objective was quickly endorsed by the several large organizations naturally concerned with the health and welfare of children. In November 1944 a committee representing the American Academy of Pediatrics, the American Pediatric Society, and the United States Children's Bureau, formulated the above quotation to indicate the eventual goal.

The first consideration in such an effort was necessarily to secure nation-wide information as to current available resources and needs for development. This was a tremendous and expensive task for the Academy of Pediatrics to undertake, and only the willing and wholehearted support of the United States Children's Bureau and the United States Public Health Service has made it reach accomplishment. Other interested organizations have contributed freely and generously to the study. The National Foundation for Infantile Paralysis, the National Institute of Health, the Field Foundation and several commercial firms have all given substantial financial support to the national study, and many local organizations have helped with their own state's activities. In South Carolina the cost of the project was divided equally between the Division of Maternal and Child Health of the State Board of Health and the county chapters of the National Foundation for Infantile Paralysis.

The actual survey in South Carolina, as in other states, represents a meticulous effort to determine local conditions bearing on child health. Data were obtained by personal interview and by mail questionnaire, and were collected and reviewed carefully by experienced workers. Under the direction of Dr. William Weston, Jr., State Chairman, Dr. Henry W. Moore of Columbia was secured to supervise the collection of information. In this task he was assisted by Mrs. Jean Hydrick, secretary, Mr. Jack Rhodes, assistant and field worker, Mr. William Lummus and Mr. Jesse Bowers as field workers. Very considerable help was given to the survey by Dr. G. S. T. Peebles of the Crippled Children's Division of the State Board of Health, Dr. George Bunch of the Dental Hygiene Division of the State Board of Health, Dr. Hilla Sheriff of the Maternal and Child Health Division of the State Board of Health, Mrs. Robert King, Department Secretary of the American Legion, Columbia, South Carolina, and Mrs. D. McLaurin McDonald, state secretary of the South Carolina Tuberculosis Association.

The pediatricians of the state spent individually a great deal of time and effort in securing proper returns. The actual preparation of this report has been delegated by the State Chairman to Dr. J. I. Waring of Charleston.

Since the national report already has been published an effort has been made to abbreviate such parts of this report as are covered fully in the broader publication. Some minor liberties have been taken with some of the figures in order to achieve round numbers. It must be realized that some of the figures given are not exactly comparable, as it has been necessary to utilize information which was perhaps not always coincidental with the data of the survey. No attempt has been made to cover all the broader phases of either private or public health services. Neither has it been possible, because of the lack of proper standards, to indicate satisfactorily how well

or how poorly our available facilities measure up to an ideal practical program of child care.

INTRODUCTION

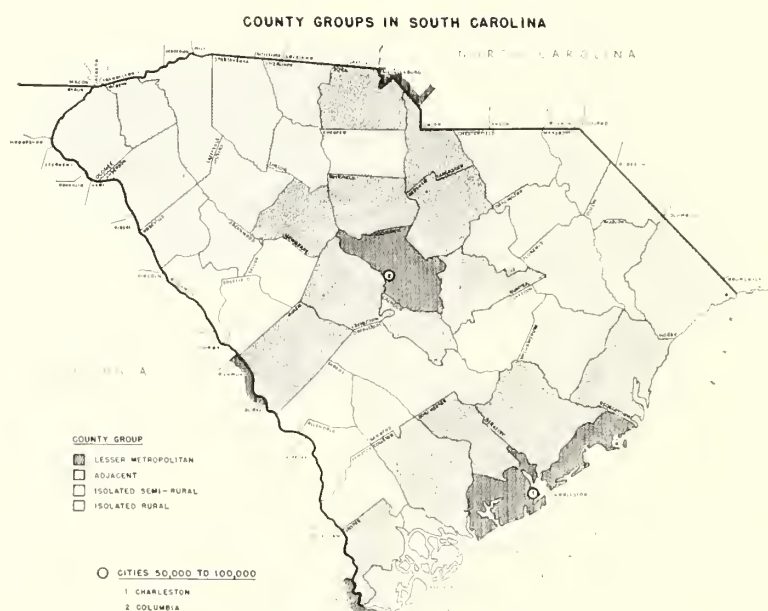
The figures which follow represent information obtained from physicians and dentists in private practice, voluntary and official community health agencies, and hospitals caring for children. They were obtained in 1946, as carefully and as accurately as possible, almost entirely through the members of the medical and dental professions themselves. They represent a candid estimate of facilities available and actual current accomplishment. Figures to include the whole state are based on reports obtained from 448 of the 712 general practitioners, 25 of the 26 pediatricians, and 164 of the 229 other specialists, or a total of 66% of the physicians in private practice in the state. One hundred and eighty-one of the state's 331 dentists and all of the 71 hospitals caring for children furnished reports. The figures from these should build a reliable frame-

work for a view of our facilities and our deficiencies, and afford a solid skeleton on which to construct a body of health for the children of the state.

First let us consider briefly the economic condition of the state of South Carolina, with whose deficiencies the thinking inhabitants are probably all too familiar.

Whatever our defects may be in various respects, in the matter of child production we stand next to the head of the list of the states with 33.7% of our entire population in the age group under 15 years.¹ This gives us a population of 713,356² children in the state, a majority of whom reside in rural communities.

For the purpose of this survey a division of counties of the state was made according to the size of the largest city and the proximity to densely populated areas. The accompanying map indicates this classification. Distribution in the several groups was as follows:



CHILDREN IN EACH COUNTY GROUP

County Group	SOUTH CAROLINA		UNITED STATES
	percent	number	percent
Greater metropolitan	0	0	23
Lesser metropolitan (over 50,000 pop.)	13	89,832	24
Adjacent to greater or lesser metropolitan	24	171,309	16
Isolated semi-rural	56	403,092	27
Isolated rural	7	49,123	10

¹ Figures for 1940. "Children" hereafter refers to this age group.

² Figures for 1945.

This classification is the one used in the national survey. For us who are accustomed to the many very thinly populated areas of the state, it is a little difficult to consider classifying such relatively large communities as Greenville and Spartanburg as "isolated semi-rural," especially since each of these particular counties includes about four-fifths as many children as does Charleston, the largest in child population. Therefore, while the statistical figures will correspond with those from other states, we may from a provincial point of view find them somewhat subject to modified interpretation. Reference to the table of child population in our counties, placed at the end of this study, will help to clarify the adjustment.

Now with this relatively large mass of children to be fed, clothed, educated and kept well, let us pass on to the somewhat depressing consideration of our financial resources whereby we may effect the desired ends. In 1944-46 the per capita income for the country as a whole was \$1,141. All the southern states were in the lower third of the income list with South Carolina third from the bottom, showing a figure of \$661, and topping only Arkansas and Mississippi. Eighteen counties in South Carolina had a per capita income of less than \$500 a year. Thus by standards of the country we are obviously poor folks.

Poor folks in large communities may get very good medical care but when they live in truly isolated areas they are unlikely to have it. Our infants died more numerously than those of our neighbors. A rate of 41.4 per 1,000 live births (1946 white rate 33.8, negro 51.0) compares badly with the national rate of 33.8, and puts us fourth from the last on the list of states. It is depressing to note that 17% of the infants who died received no medical attention.³

In the way of medical care of children as summarized from this study we stand almost as low—fifth from the end. Comparisons may help the picture:

In dental care we sink lower still to 1.0 child per day per 1,000, compared to 3.3 for the whole country, and 7.2 for Massachusetts, the top state.

With our large population of children we have relatively few physicians to care for them, and for the population as a whole.

Here then stands South Carolina, rich in children, poor in money, lacking in physicians, dentists, nurses and hospital facilities where they are needed badly. Let us examine some of the details of our deficiencies.

The Picture of Medical Care for Children of the State

On an average day 6,355 children in South Carolina were under care by physicians, either in hospitals, at home, in offices or in clinics of various sorts. These were not all actually sick children, as among children other than newborn one-fifth of the visits were for health supervision rather than for the treatment of actual illness. Only a small number of the total children were seen in well-child conferences, only 41 of the total number per day, to be exact.

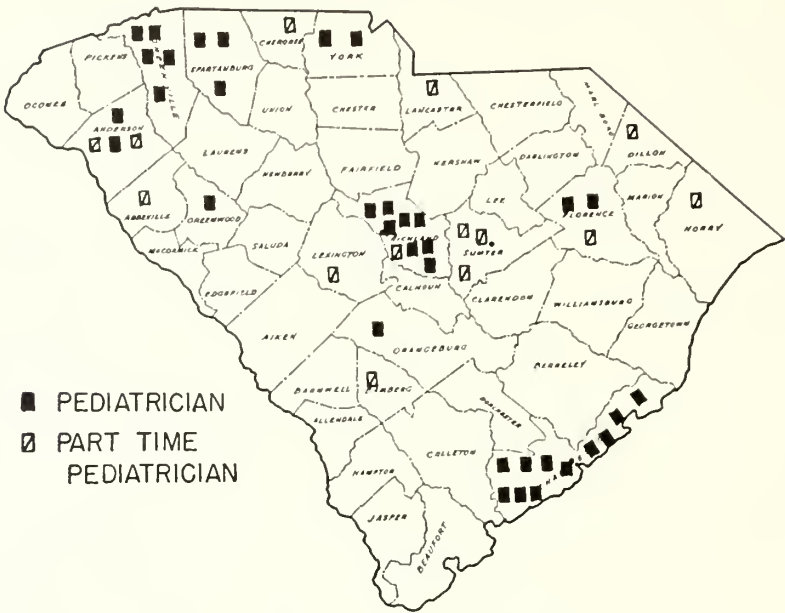
Of the total number of children seen daily by physicians in their private practice 83% were handled by general practitioners, 7% by pediatricians and 10% by other specialists. The small portion of pediatric work done by pediatricians of the state indicates the importance of the general practitioner in the picture of pediatric medical care, and points again to the obvious desirability of having the general practitioner include as much pediatric training as possible in his undergraduate and postgraduate training. In 1946 there was a relative scarcity of pediatricians in South Carolina and while the number has increased considerably, the ratio of pediatricians to general practitioners has not changed appreciably. It is possible that pediatricians are in some areas not employed by the public as liberally as they might be for strictly pediatric practice, as it is well recognized that there is a tendency

CHILDREN UNDER MEDICAL CARE PER DAY PER 1,000 CHILDREN

	Total	Private Practice ^o	Hospitals	Clinics
United States	13.8	10.7	2.7	0.4
Highest State	22.9	16.9	3.8	2.2
North Carolina	9.9	7.5	2.1	0.3
SOUTH CAROLINA	8.9	7.4	1.4	0.1
Georgia	8.6	7.1	1.2	0.3

^oOffice and home visits.

³ Figures from State Board of Health.



for children over the age of a few years to drift to the family doctor.

According to the figures as they stand in the summary, it would appear that pediatricians

paid more visits in isolated semi-rural and isolated rural counties than in the heavily populated areas, but this impression is colored by the method of classification of counties (see above).

	Number of children per physician	Number of children per pediatrician	Physicians' child visits per day per 1,000 children
United States	308	10,299	13.5
Highest State	143	4,182	21.8
North Carolina	764	31,090	9.1
SOUTH CAROLINA	738	27,437	8.9
Georgia	536	13,811	8.6

	Beds in general hospitals per 1,000 children	Full-time Public Health Nurses per 100,000 children
United States	12.8	40.4
Highest State	28.5	101.1
North Carolina	7.6	30.6
SOUTH CAROLINA	6.6	23.6
Georgia	6.8	30.5

Area	Number of general practitioners	General practitioners per 100,000 children	Children per general practitioner
Whole State	712	100	1,000
Lesser Metropolitan	106	118	850
Adjacent	151	88	1,130
Isolated Semi-Rural	415	103	970
Isolated Rural	40	81	1,220

Area	Number of pediatricians	Pediatricians per 100,000 children	Children per pediatrician
Whole State	26	4	27,500
Lesser Metropolitan	13	14	7,000
Adjacent	2	1	85,000
Isolated Semi-Rural	11	3	37,000
Isolated Rural	0	--	--

	Practicing Physicians per 1,000 Persons	Persons per Practicing Physician	Practicing Physicians per 1,000 Children	Children per Practicing Physician
United States	0.8	1200	3.2	308
SOUTH CAROLINA	0.5	1933	1.3	737

PERCENT OF TOTAL PRACTITIONERS IN SEPARATE GROUPINGS

	General Practitioners	Pediatricians	Other Specialists
United States	64%	3%	33%
SOUTH CAROLINA	74%	3%	23%

Health Supervision

On an average day in South Carolina 1,114 children, excluding newborns, received individual health supervision, which represents 20.4% of the total medical care received by those children on that day. All the general practitioners did roughly six times as much as all the pediatricians.

Of the above number, 814 were in the infant and pre-school group, showing that three-fourths of the health supervision visits were concentrated in the younger ages.

The general practitioner saw 82.4% of the sick children and 86.5% of the well children cared for in private practice, compared to 5.5% and 11.9% respectively, for the pediatrician. The remaining pediatric work was done by other specialists.

Health Supervision of Infants and Pre-School Children

In a group including infants and pre-school children medical service for health supervision was given to 267.9 per 100,000 children under age 5 per day. As indicated before, the pediatricians were relatively more active in this field, caring for 16% of these children in their private practice, which segment represented more than half (54%) of the pediatricians' practice. The general practitioner took care of about 78% of the children who received

health supervision, a number which represented 9% of his practice. The 26 pediatricians in their private practice took care of almost three times as many children for health supervision as did all the well-child conferences.

Summary of Data on Pediatricians in South Carolina

If pediatric care is primarily the domain of the well trained pediatrician, it is well to examine the qualifications of our specialists. Whatever they may be, the qualifications of the general practitioner are almost certain to be less impressive in a broad program of child health.

In 1946 information on 25 pediatricians (i.e., specialists in pediatrics) in South Carolina showed the following:

Postgraduate training as reported by 22 pediatricians showed that half had less than 6 weeks and half had six weeks or more.

These figures are not impressive for training of specialists, but are by and large not bad. The general practitioner who cannot afford long training in the specialty of pediatrics and who cares for the vast majority of children in this state, must get adequate instruction in his undergraduate pediatric training, and by postgraduate instruction. For

Total Hospital Internship and Residency:	Number of Pediatricians	Hospital Training in Pediatrics	Number of Pediatricians
none or less than one year	1	less than 1 year	3
1 to 3 years	12	1 to 2 years	9
3 to 5 years	12	2 to 3 years	11
5 or more years	0	3 or more years	2

HOSPITAL TRAINING OF GENERAL PRACTITIONERS IN SOUTH CAROLINA
AS COMPARED WITH UNITED STATES

	SOUTH CAROLINA	United States
None or less than one year	27.2%	20.7%
One year or more:		
with none or less than one month in pediatrics	26.8%	27.2%
with one month or more in pediatrics	46.0%	52.1%

DATA ON HOSPITAL TRAINING BY AGE OF GENERAL PRACTITIONER
IN SOUTH CAROLINA

	Under 45	45-64	65+
None or less than one year	7.0	33.8	61.3
One year or more:			
with none or less than one month in pediatrics	17.1	35.4	27.9
with one month or more in pediatrics	75.9	30.8	10.8

obvious reasons, it would seem that pediatrics should be a very large feature of the curriculum of the Medical College of the state, which supplies the greatest part of our practitioners.

The figures show an encouraging increase in pediatric training among the younger men.

The practitioner in South Carolina is fortunate in having available just across the North Carolina border an annual post-graduate seminar of two weeks' duration, at which the field of pediatrics is reviewed and recent advances considered. About twenty general practitioners of the state attend this session every year. Scholarships are available from the State Board of Health and encouragement is given to the man in general practice to bring his pediatric knowledge up to date.

Nursing Service

All of the 168 Public Health nurses of the state,⁴ including eleven negro nurses, served full-time. Only 33, based on 153 reporting, had completed one year of public health nursing

⁴ Exclusive of nurses employed by agencies giving only school health, industrial, tuberculosis, or venereal disease services; exclusive of nurses reported as supervisors employed by state agencies. If a nurse serves more than one county, considered only in county of her headquarters.

training. These active and capable workers paid a total of 41,119 home visits to children during the year. They were available in the ratio of 23.6 nurses to each 100,000 children of the state. Ninety-three of the nurses worked in rural or semi-rural counties (as classified), and one-half of all visits paid were made in these counties.

In 1946 there was one nurse to each 4,247 children in the state. It should be emphasized that these nurses did not devote their full-time efforts to children but carried the load of other phases of public health nursing. The usual estimate of need is one nurse to each 5,000 total population, or one to 2,000 if bedside care is included. In terms of child population South Carolina would require one full-time pediatric nurse for 674 children in the state. Thus we might well use six times the strength of the present nursing staff. With the recent decrease in the number of graduating nurses, it is unlikely that it will be possible to approach at any early time the desirable increase in public health nurses for the state.

General Hospitals

South Carolina has 66 hospitals which admit children or maternity cases. Of these, 65 include maternity departments. Fifty-nine admit children, but there is no entirely pediatric general hospital in the state.

INDICES OF PUBLIC HEALTH NURSING SERVICE TO CHILDREN

	Public Health Nurses (full time) Per 100,000 Children	Child Home Nursing Visits Per 1,000 Children	Percent Counties Giving 3 Types of Service ¹	Percent Counties Giving 4 Types of Service ²
United States	40.4	209.8	41.1	18.6
SOUTH CAROLINA	23.6	57.6	75.6	37.8

¹ Assistance in well-child conferences, home visits for health supervision, school nursing services.

² Includes bedside nursing in addition to other services.

About 45% of admissions of children were to the smaller hospitals with less than 100 beds. There were only 11 hospitals with 100 or more beds, of which 4 had 250 or more beds.

In all of these hospitals during the study year there were born 21,414 babies, who remained in the hospitals for an average stay of 6.8 days and were accommodated in 882 bassinets and 118 incubators. Only 49.7% of the live births in South Carolina in 1946 were in hospitals. Of the total births 76% of the white, 14% of the negro were in hospitals. 47% of the hospital births were in institutions which lacked certain desirable characteristics. (See below)

During the year over 25,000 children were admitted to general hospitals in the state. Four hundred and eighty-three beds assigned to pediatric cases took care of about 65% of these children. Nearly half (48%) of the admissions were to hospitals lacking certain desirable characteristics.⁶

More children were admitted from the isolated semi-rural and the isolated rural counties than were admitted from the more thickly populated counties. Almost four times as many white children were admitted as were non-white. Here again the interpretation is tinc-

tured by the classification of some of our more populated counties in the class of isolated semi-rural.

Acute poliomyelitis cases were accepted for diagnosis and care in 30 hospitals, for care alone in 9. There are no separate hospitals for communicable disease (other than tuberculosis) in the state.

The status of our 20 small hospitals (5-24 beds) is not above reproach. Only 7 of the 20 are registered by the American Medical Association. Eight have x-ray service. Only 2 have clinical laboratories. For newborns, 12 have separate nurseries but only 5 have a graduate nurse on duty at all times in their newborn nurseries.

In respect to newborn care the group of larger hospitals (with 25 or more beds) makes a much better show, with 91% registered. Only 18% had house staffs; 91% had separate nurseries; 73% had graduates on duty at all times in the nurseries. Only 11% had separate isolation nurseries; only 34% had formula rooms, and a few (7%) did not sterilize milk formulae for the newborn. This group of hospitals took care of 93% of the hospital births.

Passing from the consideration of the care of the newborn to that of sick children in general, we find the picture to be as indicated in the following table:

CHARACTERISTICS OF CARE FOR SICK CHILDREN IN LARGER GENERAL HOSPITALS
(25 OR MORE BEDS) IN SOUTH CAROLINA

Characteristic	Percent of Hospitals With Specified Characteristic
Registered by American Medical Association	91.3%
Separate Pediatric unit	37.0%
Separate ward for infants other than newborn	13.0%
Any house staff	17.8%
Graduate nurse on duty at all times in pediatric unit	28.3%
Clinical laboratory in hospital ¹	55.6%
Qualified dietitian on staff	52.3%
All milk pasteurized for infants and older children	78.3%
Selected clinical laboratory services available ²	35.6%

¹ At least the following 3 types of service are available—bacteriology, biochemistry and hematology.

² Blood level for sulfonamides, sedimentation rate, blood culture and serum protein.

27.5% of child admissions were to the large general hospitals of 250 beds or more; 27.2% to those with 100 to 249 beds, 41.8% to those with 25 to 99 beds, and the balance of 3.5% were to hospitals with less than 25 beds.

Only 6 general hospitals in the state main-

tain out-patient departments that admit children; only 4 of these have separate pediatric clinics; only 1 has a child's dental clinic. To these 9,717 visits are made each year. In the United States, 62 visits per year per 1,000 children were made to such clinics; in South

⁶ The items required for approval were:

1. Registration by American Medical Association.
2. Any house staff—includes interns, assistant residents, residents and fellows.
3. Separate nursery for newborn only.
4. Graduate nurse on duty at all times in newborn nursery.
5. Nursery for full-term sick or suspect newborn separate from well.
6. Room used exclusively for preparation of formulae.
7. All milk mixtures sterilized for newborn.

Carolina, only 13.6 visits. Paucity of clinics, not abundance of health, is the probable reason for the disparity.

It is interesting to compare certain findings of the Health Facilities Survey made by the Research, Planning and Development Board of South Carolina in 1947. The statements in the following quotations from this survey are in general similar to those facts found by the Academy survey.

"There is need for, and there should be, a closer cooperation between the Health Department and hospitals."

"The hospital survey in South Carolina revealed that no hospitals were set aside or designated as contagious disease hospitals, and it is not recommended that this type of hospital be built. The larger hospitals throughout the State are coping with this type of illness in a very satisfactory manner by having isolation quarters."

"Eighteen general hospitals out of sixty-one for the State have organized out-patient departments."

"Medical social service departments have

become highly organized and utilized in hospitals over the nation. Hospitals in South Carolina have lagged far behind in offering this service to the sick of the State. There is a definite need for medical social service in all general hospitals in South Carolina. Three hospitals out of sixty-one have this service available."

"South Carolina is wholly lacking in dental service to the indigent or near indigent. Out of sixty-one general hospitals in the State only eight hospitals have dental clinics."

"Only nineteen of South Carolina's general hospitals have facilities for pediatrics, and some of these are inadequate."

"Sixteen general hospitals out of the sixty-one for the State have registered dietitians in charge of the dietary department."

"The survey revealed that 33 percent of the total number of hospital beds in the State are negroes. In 1940, negroes constituted 43 percent of the total population for the State of South Carolina. It is reasonable to assume the need for negro hospital beds will increase as the purchasing power of the negro increases."

(To Be Continued)

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

THE COST OF MEDICAL CARE*

The main argument used by proponents of compulsory government health insurance that many million of Americans can't afford adequate medical care.

That argument falls flat on its face in the light of the facts. According to the Brookings Institution, which makes authoritative surveys on various problems, medical care costs the average American family about 4 percent of its income. By comparison, taxes direct and indirect, take 20 to 30 percent of that income!

Furthermore, the compulsory insurance scheme would cause a very heavy increase in the tax burden. No one knows how much it would cost. Government officials have estimated the annual bill at \$4,000,000,000—and estimates such as this are almost always low. Other analyses place the cost at \$6,000,000,000, and more. At best, the medical bill of the American people would be doubled and it might be tripled. And the fact that we would pay for it through payroll and other levies, instead of by writing out a check to the doctor, wouldn't make it any less burdensome.

Contrast this with the non-profit medical care plans, which now cover some 55,000,000 people, and which are growing at a healthy rate. An average plan over

the nation, giving surgical, medical and hospital protections, costs \$2.50 a month for an individual and \$5.50 for a family—less than most of us spend for such non-essentials as cigarettes. And these voluntary plans don't put politics into the practice of medicine.

It is true that there are indigent people who can't afford to pay anything for medical attention. Here is where government can help—and it can do it without starting us on the downhill road that leads to socialized medicine. One way should be for the government to pay for these people's memberships in approved, non-profit plans.

BLUE SHIELD FACTS

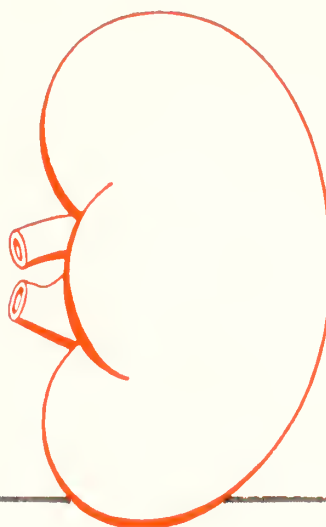
(Continued from last month)

- Q. Who are the present officers of the Blue Shield Plan?
- A. Dr. J. D. Guess, of Greenville, is President; Dr. George W. Wilds of Hartsville, Vice President; Dr. John D. Ashmore of Greenville, Treasurer; and M. L. Meadors of Florence is Acting Secretary.
- Q. Who are on the Board of Directors?
- A. The four named above, and Dr. W. Wyman King, Batesburg; Dr. John A. Seigling, Charleston; Mr. Jesse T. Anderson, Columbia; Dr. J. Howard Stokes, Florence; Dr. C. R. F. Baker, Sumter; Dr. W. T. Barren, Columbia; Mr. Earl R. Britton,

* Reprinted from the editorial column of the Florence Morning News, August 20, 1949.

To increase sodium excretion

"Thus it becomes apparent that Aminophyllin is a diuretic agent in that it can mobilize and excrete fluid and sodium even in the face of decreased intake."¹



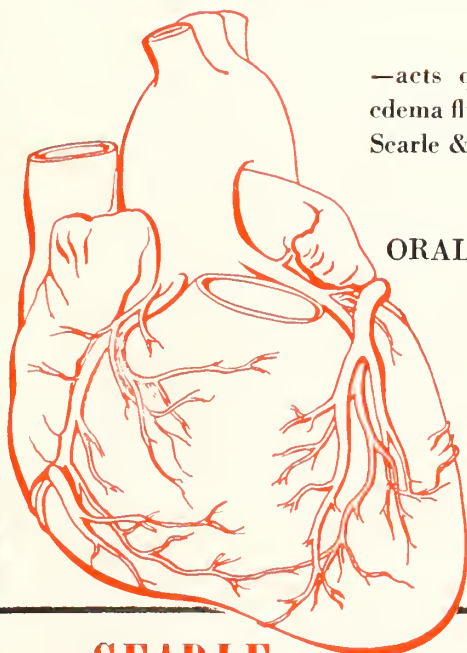
SEARLE

AMINOPHYLLIN*

—acts quickly and efficiently to eliminate edema fluids in congestive heart failure. G. D. Searle & Co., Chicago 80, Illinois.

**ORAL—PARENTERAL—RECTAL
DOSAGE FORMS**

**Searle Aminophyllin contains at least 80% of anhydrous theophylline.*



SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

¹ I. Brown, W. E., and Bradbury, J. T.: The Effectiveness of Various Diuretic Agents in Causing Sodium Excretion in Pregnant Women, *Am. J. Obst. & Gynec.* 56:1 (July) 1948.

Columbia; Mr. R. C. Edwards, Abbeville; Dr. George D. Johnson, Spartanburg; Dr. A. C. Bozard, Manning; and Mr. W. W. Lowrance, Sumter.

Q. How was the fee schedule worked out?

A. The present professional members of the Board of Directors were appointed by Council in January as a Committee on Fee Schedule. They included representatives of General Practice, Surgery, Ophthalmology and Otolaryngology, Obstetrics and Gynecology, Orthopedics, Urology and Pediatrics. The Committee held several meetings in the spring, studied, individually and collectively, the fee schedules of other plans, and after contacting other members of their specialty or general practice groups in the State, agreed on the schedule.

Q. How does it compare with the fee schedules of other plans?

A. It is in line with the schedules of plans in our section of the country, and follows closely the schedule now in effect in North Carolina. Changes were made where the Committee thought them advisable, but actually they were few. The Schedule was submitted to Council and approved by that body for referral to the House of Delegates. Mimeographed copies were mailed to the members of the House of Delegates in advance, and at the annual meeting in May, the schedule was adopted as submitted, without dissent.

Q. Are surgeons and obstetricians the only physicians expected to participate in the plan?

A. No—if those terms are construed to mean only those who specialize in surgery and obstetrics. The plan provides payment for the services specified when performed by any qualified physician.

Q. In what way can a general practitioner benefit from the plan?

A. General practitioners will be paid for obstetrical cases and any minor or other surgery performed by them. In view of the obstetrical cases handled by most general practitioners, they should be among the physicians most affected.

Q. Why are not medical services as distinguished from surgical and obstetrical services, covered by the plan?

A. Experience in other plans has shown this to be impracticable in the beginning. In fact, the experience of the insurance companies generally, has indicated that it is almost impossible to insure on a safe, economic basis against sickness not caused by accident or involving some surgery, without rather strict limitation. In brief, the opportunity and temptation to take advantage of the provisions has proved too great for insurance against sickness in the home.

Q. Will it be possible to include these later?

A. Certain committees from the Board of Directors of the plan are now looking into the feasibility of including within the provisions of the subscriber's

agreement, payment for medical treatment by the physician in the hospital after the second day's stay. Preliminary inquiry indicates that it may be possible to include this item at very little additional cost to the subscriber. The Board has taken no action on this and there is nothing definite about it, but if possible, this will doubtless be included.

Q. What connection, if any, is there between Blue Cross and Blue Shield?

A. The corporations offering the two plans are entirely separate and distinct. Each has its own membership and Board of Directors, its working capital and subscribers, and rules and regulations. Representatives of the Blue Shield Plan, however, have already met with the Board of Directors of Blue Cross and discussed tentatively, the terms of a proposed agreement whereby the administrative staff of Blue Cross (The South Carolina Hospital Service Plan) will handle the sales, book-keeping, promotional and development work of the Blue Shield Plan. This arrangement is in effect in a number of the states and has worked very satisfactorily. It serves to reduce overhead and enable both plans to operate more economically, it makes for further cooperation between the hospital and physicians' service, and, most important feature, it is thereby possible to offer to the public, hospital and professional cost insurance in one package, and at the same time. Representatives of Blue Cross believe that the ability to offer medical service as well, will boost their sales considerably. The financial structure of both plans, however, will remain entirely separate and distinct.

Q. How will subscribers to the plan be obtained?

A. If the arrangement discussed in the answer to the foregoing question, is effected, the subscribers will be obtained primarily through the sales personnel offering Blue Cross and Blue Shield. Blue Cross already has four or five district offices located in South Carolina, and others are contemplated. Each of these is equipped to serve several counties. The sales personnel are full-time employees of the plans. Neither Blue Cross nor Blue Shield is sold, like other insurance, through agents earning commissions. Enrollment will be only by groups and not of individuals.

Q. What will be the cost of Blue Shield to the subscriber?

A. This has not yet been definitely determined. A Committee from the Board of Directors has been at work on the problem for several months. From the studies already made by actuaries, experienced with this type of coverage, it appears that it may be possible to offer contracts to individual subscribers at somewhat less than \$1.50 per month, and family contracts at \$2.50 per month, or probably less. Care will be taken not to make the subscription payments too low in the beginning and run the risk of having to raise them soon, and



QUESTION:

When is it good practice to suggest "Change to Philip Morris Cigarettes"?

ANSWER:

When patients under treatment for throat conditions persist in smoking, many eminent nose and throat specialists suggest "Change to Philip Morris"* ...the only cigarette proved** less irritating.

● *In fact, for all smokers, it is good practice to suggest "Change to Philip Morris."*

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*Completely documented evidence on file.

**Reprints of published papers on request:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

thereby increase buyer resistance.

- Q. How do these amounts compare with insurance offered by stock companies, against the same risks?
- A. Generally speaking, they are considerably less. It is hard to make any definite comparison because of the difference in the provisions of the contracts. As a rule, however, Blue Shield offers more for the money to the subscriber, and this accounts for its popularity particularly among the lower income groups.
- Q. Is Blue Shield designed to take the place of the conventional types of insurance now available from the stock companies?
- A. No. There is no intention nor desire on the part of those interested in Blue Shield to displace the well-recognized forms of insurance which have been on the market for many decades. Blue Shield, like Blue Cross, offers primarily a service contract. They are designed principally for people who wish and need to obtain protection against the costs of hospital and medical services for the least money. Blue Shield will have no particular advantage over the stock companies for subscribers whose annual family incomes exceed \$3500.00. For these subscribers, Blue Shield would do only what stock companies would do—furnish a fixed amount to be applied on the professional fee.
- Q. What is the attitude of Blue Shield toward the stock companies?
- A. They are looked upon as competitors furnishing a different type of protection against the hazards of sickness and hospitalization. It is recognized that there is ample place in the field for both types of coverage. People who have carried insurance with the stock companies heretofore, will doubtless continue to do so. Blue Shield is expected to reach, primarily, a large number of people who previously have had no protection at all.
- Q. Are Blue Cross and Blue Shield in any sense "socialistic"?
- A. No. Very much to the contrary, they are designed to arrest the socialistic trend. They are not owned, controlled or subsidized by the state or federal government. Subscribers do not become part owners. They are primarily service organizations and simply because they are not organized for profit, is no indication that there is anything whatever socialistic in their organization or method of operating.

(to be continued)

BLUE SHIELD IN MICHIGAN

As South Carolina physicians consider seriously, and make plans for beginning operation of their own medical care organization, they will be interested in the experience of plans now operating, and the success or failure of methods already adopted.

One of the most successful plans in the country has been Michigan Medical Service, whose history is related in the June, 1949, issue of the Journal of the Michigan State Medical Society.

Although its subscribers at the present time number well over 1,000,000, and its financial reserves amount to about \$2,000,000, the life of Michigan Medical Service has not always been a bed of roses. We may always profit by the experience of others, and it would be well for the members of the South Carolina Medical Association to give some thought and attention to the experience which the new successful Michigan organization had in its beginning and formative years.

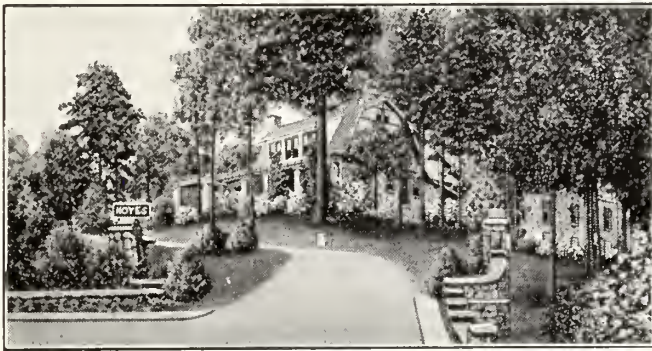
The Michigan plan began operation on March 1, 1940. It first offered a complete medical care program covering medical services rendered in the patient's home, the doctor's office, and the hospital. The objective of the doctors of Michigan was to provide a medical program that was complete in every respect.

That, indeed, is the ideal which any medical organization would hope to attain, but the experience of Michigan points rather clearly to the impracticability of such a plan. We may say in passing that some of the same features which prevent the feasibility of a nationally-controlled scheme of compulsory health insurance, would to a large extent also render impracticable a similar all-inclusive plan, operated even by the medical profession itself.

"In the absence of actuarial data," the history of MMS continues, "the rate for this complete medical care program was set at \$4.50 a month for a full family—a figure which proved to be barely half the actual cost of providing service to the average family at that time. In spite of this half-cost figure, the program attracted only negligible public interest. There developed almost immediately a considerable public pressure for protection against the costs of only major illness, and in response to this pressure Michigan Medical Service developed a program providing for surgical care in hospital cases. In twenty-seven months more than 350,000 persons were enrolled for this limited or surgical protection. During the same period of time, the maximum number enrolled under the complete medical care program was only 7,375 persons. Because of lack of public interest, the complete medical care program was discontinued in June, 1942."

It is still the intention of the Michigan organization to broaden the coverage as rapidly as possible, and has carried out a survey in the State through a method of sampling public opinion, for the purpose of determining the extent of the public interest in a program providing for medical care generally.

Michigan found that, although rates for the surgical care program were established to cover twice the amount of surgery normally required by the population in that State, this was insufficient by a wide margin. At one time, the amount of surgery required by subscribers to the Service was nearly four times the normal requirement, and rate adjustments necessarily were made upward.



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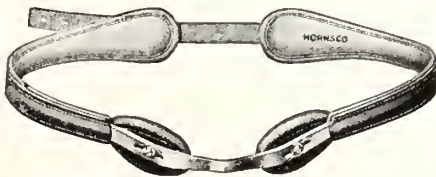
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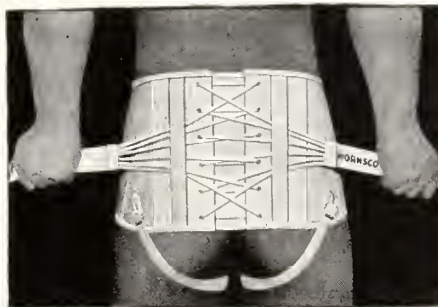


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As would be expected, the great majority of subscribers to the Michigan program, thus far, are employees of business and industrial establishments. Incidentally, the enrollment of the Ford Motor Co. in November, increased the membership by 27.5 percent for the year, and brought the total enrollment to more than a million and a half. But the program is not confined to industrially employed groups, despite the prevalence of these in the State of Michigan.

"For the enrollment of farmers a very active program is under way. Over 650 farm groups already have been enrolled through Farm Bureaus, Granges, farmer co-operatives and the Farm Security Administration.

"For the enrollment of the self-employed and others who do not belong to an eligible group, Michigan Medical Service and Michigan Hospital Service have a program of community enrollment through which interested persons in practically every part of the state, periodically, are given the opportunity to obtain protection through these two organizations.

"For persons who cannot afford to pay, Michigan Medical Service and Michigan Hospital Service are seeking a means of co-operating with the government, whereby "wards of government" and the indigent will not be segregated in charity facilities but will be entitled to the same sort of service as any subscriber and, for all practical purposes, will be indistinguishable from subscribers paying their own way. The program providing for the care of veterans in service-connected cases offers a suggestion as to how this objective may be realized."

The difference in the problems of administration of a medical service plan and a hospital service organization, are pointed out in the further story of Michigan's development. The same will be true in South Carolina and this points up the great importance of securing the fullest cooperation possible from the members of the medical profession.

As of March 31, 1949, MMS had paid \$34,653.-626.04 to doctors for services provided in 575,574 cases. That, to our way of thinking, is no mean achievement for an organization within the space of nine years. At present one of every five residents of Michigan is protected by the Plan, and the growth in the number of subscribers last year alone amounted to 376,280 persons. It is expected that within a few years, a majority of the entire population of the State will be covered by Michigan Medical Service.

From a high of 20.05 percent of income paid for administration of the Service in 1940, the cost has dropped steadily to a low of 10.99 in 1947. There was a brief rise again in 1948, to 11.81, occasioned no doubt by the heavy new enrollment experienced that year. This percentage of the total income, necessarily applicable to cost, is in line with the experience of the most successful plans, generally, throughout the country. The writer of the article sums up the general opinion on the Plan as follows:

"Michigan is a single state and cannot speak for the balance of the nation. However, it is believed that the grass roots approach, which is highly sensitive to public demand and local requirements, has been fundamentally responsible for the development of the Michigan plan. It is characteristic of the more or less spontaneous growth of developments such as these that they spread very rapidly, with each locality throughout the nation borrowing the best features of local accomplishments elsewhere."

And the following, we believe, truly expresses the type of cooperation which would lead to the nearest complete solution to the problem of the rendition of medical service to those otherwise unable to obtain the same:

"From our experience in Michigan, we are certain that a true spirit of cooperation between voluntarily health care organizations and governmental health agencies can produce for the nation the most effective, enduring and progressive system of health care. Voluntary health organizations should not attempt to do the whole job any more than should government attempt to do so, for the reason that any monopoly of health services, whether economic or otherwise, inevitably will lead to degeneration of the entire system. For greatest continued progress, it is imperative that there be maintained the sort of health care system which is characterized by a proper spirit of competition and by the existence of natural balances and checks in the best American tradition."

MEDICAL SERVICE AND SOCIALIZED MEDICINE*

By Hon. Arthur H. Vandenberg
Senator from Michigan

There is vast propaganda today for socialized medicine. I think it would destroy precious personal relationships in the American way of life, produce wholesale mediocrity in the skills which serve the sick, and saddle us with a new and appalling bureaucracy. But this does not require me to blind my eyes to the existence of a crushing and well-nigh universal sick problem in the lives of millions of our citizens. It is a problem that must be met. But we have a choice of methods. One is voluntary and therefore typically American. The other is involuntary and therefore typically bureaucratic. The latter is socialized medicine. The former is co-operative medicine. I expect the American people and the Republican Party to choose the former. I want my party to look at the great, humanitarian, co-operative effort of the Blue Cross, for example, which represents co-operation and not compulsion. It comes to finest fruition here in

* Reprinted from the Congressional Record, February 14, 1949.

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Bibliography: (1) Hyman, H. T.: An Integrated Practice of Medicine, Philadelphia, W. B. Saunders Company, 1947, vol. 3, p. 2503.

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Michigan where one of four of our people already thus have cheaper and better protection than they would ever get from socialized medicine. Probably two out of four of our Michigan people are covered by this or other voluntary plans.

BLUE SHIELD IN RURAL AREAS

With South Carolina so predominantly rural, and with Blue Cross and Blue Shield both operating on the basis of group enrollment, people are apt to inquire as to the probability of the success of these organizations in this State. Some may be inclined to think that, while the experience is good in industrialized areas, the conditions among farming groups are such as to render them impracticable. That, however, has not been the experience in some of the places where Blue Cross and Blue Shield have been operating most successfully.

Michigan is a case in point. Its Medical Service is now enjoying as successful an experience as any other plan in the country.

At the close of 1948, according to an article in a recent issue of the Journal of the Michigan State Medical Society, approximately 30,000 persons were enrolled in Blue Cross through 580 Michigan Farm Bureau groups. At the same time, 3,000 members of 50 Grange organizations were also enrolled. A total of 9,000 new Blue Cross members were added through 114 Farm Bureau groups in 1948. This represented a greater increase in enrollment than in the previous year, among rural groups, and was the result of much time devoted to education of the organizations in the matter of enrollment and servicing. According to the article, payments from the rural groups are on a collection system. Each organized county has a county-wide Blue Cross Secretary through whom the organization functions. Yearly training conferences are held for the various secretaries in each county. Numerous rural groups have added the surgical or the medical-surgical service to the hospital plan, by which alone they were previously protected. As a result, at the present time more than half the rural subscribers have full hospital and surgical service, and most of the new groups are taking all three of the services available.

Attention is now being given to the enrollment of subscribers to Blue Cross and Blue Shield in Michigan on a community, and in some instances a county-wide basis. Such development naturally comes about only after years of experience and highly centralized activity by a well-trained group. It would be neither possible nor practicable for South Carolina at the present time, but it indicates the point to which this type of insurance protection may be developed over a period of years.

At any rate, whatever the difficulties attendant upon it, this type should be highly preferable to, much more satisfactory, and far less expensive than any type of

compulsory, government-administered system of health insurance.

ASSOCIATED MEDICAL CARE PLANS

The various medical care plans operating in the different states, under the sponsorship and control of the doctors, are entirely separate entities. Each is organized and incorporated under the laws of the state where it operates. Members of the profession and others will be interested to know the extent of the connection between the various plans.

As a matter of fact, there is no organic relationship among the several plans. Each is organized independently, and is entirely autonomous. The Blue Shield Plans do, however, like the Blue Cross, have certain required standards which they must meet in order to entitle them to the use of the Blue Shield as a symbol of the type of service offered. And there is a central organization devoted to the purpose of coordinating the activities and advancing the interests of the Blue Shield Plans in general.

This organization, the Associated Medical Care Plans, was set up under the sponsorship and with the approval of the American Medical Association. At the June meeting of its Board of Trustees, in Atlantic City, the application of the South Carolina Medical Care Plan for associate membership was approved, and this organization, therefore, has already become affiliated with the Associated Medical Care Plans. A history of the latter organization, and description of its activities, was included in the June issue of the Michigan State Medical Journal, and the facts therein contained will be of interest and benefit to the members of the profession in South Carolina:

"The Associated Medical Care Plans, often referred to as 'AMCP' or 'Blue Shield', had their beginnings in the fall of 1942, when the few plans then in existence decided to get together in an attempt to help each other in problems of administration of voluntary non-profit medical service plans.

"A meeting held in Detroit resulted in the formation of the Council of Medical Service Plans of America in the spring of 1943. This was an informal association without charter, by-laws, or even any staff. Michigan Medical Service supplied much of the impetus toward the organization and its activity, as well as its chairman for the two years of its existence. Its activities consisted mostly of discussions held at times and places related to other medical group meetings.

"The plans, originally eleven in number, had by 1945 grown to forty-three, and felt the need of a more formalized organization and a much expanded and coordinated activity in behalf of its member plans.

"The present AMCP was organized in 1946 at meetings held at the AMA Headquarters in Chicago, and secured an Illinois nonprofit charter with a grant of \$25,000 from the AMA to get it started. It is now



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1. Brewster, J. M., U. S. Naval Med. Bull. 49: 1-11, January-February 1949.



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sustained by dues from the member plans. With a membership of sixty-two plans, it now represents all qualified plans in the United States with the exception of four.

"Its purposes are set forth in its constitution:

"The objects of the corporation are to promote the establishment and operation of such nonprofit, voluntary medical care plans throughout the United States, its territories and possessions, and Canada as will adequately meet the health needs of the public and maintain the high quality of medical care rendered by the medical profession. Inherent in its objects is a recognition that state and local medical care plans should be autonomous in their operation so that the needs, facilities, resources and practices of their respective areas can be given due consideration, but that the health and welfare of the public is advanced by the co-ordination through the medium of this corporation, of methods, coverages, operations and actuarial data.

"Its affairs are directed by thirty commissioners, twelve plan executives, twelve plan trustees and six representatives of the Council on Medical Service of the AMA. The officers elected by the commission are:

President—Harold L. Schriver, M. D.

Vice President—R. L. Novy, M. D.

Secretary—O. B. Owens, M. D.

Treasurer—Jay C. Ketchum

NEWS ITEMS

Dr. John D. Hilliard and family have moved to Latta where Dr. Hilliard is doing general practice.

Dr. Richard C. Horger has opened offices in Orangeburg for the practice of Obstetrics and Gynecology.

The Piedmont Proctologic Society, a sub-section, of the American Proctologic Society was organized in Asheville, N. C. on July 30, 1949. All of the Proctologists, who are members of the American Proctologic Society, in the states of Virginia, North Carolina, South Carolina, Tennessee and Georgia are eligible for membership and all of the states were represented at the organization meeting.

Dr. Issac E. Harris, of Durham, N. C. was chairman of the organization committee, Dr. C. S. Drummond, of Winston-Salem, N. C. its Secretary; Dr. Geo. F. Parker, of Asheville, N. C. the host; Dr. W. T. Brockman, of Greenville, S. C. was to select a name; Dr. C. R. Deeds, of Hendersonville, N. C. to draw up the Constitution and By-Laws.

Dr. W. T. Brockman, of Greenville, S. C. was elected its first President; Dr. C. R. Deeds, of Hendersonville, N. C. its first Vice-President; Dr. C. S. Drummond of Winston-Salem, N. C. the first Secretary-Treasurer.

The next meeting will be held in Atlanta, Ga. on December 5, 1949.

"Responsible for the execution of its affairs in its Chicago headquarters are P. R. Hawley, M. D., as chief executive officer, and Mr. F. E. Smith, director.

"AMCP has done much to encourage the development of new plans in state and local medical societies, assisted many plans with operating problems, particularly in the field of enrollment, statistics, accounting and plan relations with the public, the profession and with companion hospital service plans.

"The problem of satisfactory enrollment methods for employees of national employers has been and is receiving a great deal of attention by the AMCP. There has been some difference of opinion in this matter, AMCP and the Council on Medical Service of the AMA have not always agreed on some proposals.

"It has been pointed out that the AMCP is representative of the medical profession as is the Council on Medical Service or any other group within the AMA inasmuch as the board of member plans are, in one way or another, chosen by the local or state societies, much as they select their delegates to the AMA, and in turn, the boards of the plans selected their representatives in AMCP and its commissioners."

The 12th Annual Symposium of the Duke Medical School will be held at Durham, N. C., Thursday, Friday and Saturday, October 13, 14 and 15th. The general subject will be the "Basis of Disease". Among the guest speakers will be doctors Stanley Bradley, New York City; D. E. Clark, Chicago; John Dingle, Cleveland; Robert Elman, St. Louis; Paul Klemperer, New York; Joseph Lilienthal, Jr., Baltimore; C. N. H. Long, New Haven; William Parsons, Charlottesville; Hans Selye, Montreal and Robert Wilkins, Boston.

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ABSTRACTS

Schiff, C. A., Goldberg, S. L., Neeheles, H.: The Prevention of Abdominal Adhesions, Experimental Study on the Role of Gastro-Intestinal Motility, Surg. 25:257 February 1949.

The known factors causing the formation of adhesions, such as general health, infection, trauma, the presence of foreign bodies, and the blood supply to the parts, are discussed as well as a review of usual methods employed in prevention of adhesions.

Adhesions were produced in the peritoneal cavity of dogs by spreading 0.25 grams of surgical talcum powder over the serosal surfaces of the small intestine. The authors divided the experimental animals into two groups, in one of which every effort was made to stimulate peristaltic activity of the bowel by early feeding and repeated administration of Prostigmine methylsulfate hyperdermically. In the other group an attempt was made to suppress peristaltic activity by means of starvation and repeated administration of atropine hyperdermically.

Results of these experiments showed 71% fewer adhesions in the group in which motility of the bowel was stimulated. It was also shown that increased motility of the bowel decreased the density of the adhesions formed.

The experiments cited have clinical implications. Early feeding and early ambulation and, in selected cases, the use of Prostigmine are valuable in stimulating peristalsis. This increased activity prevents the peritoneal surfaces of bowel from remaining adherent to other mesothelial surfaces long enough to permit fibrous union. If the fibrinous agglutination of the surfaces can be prevented during the first few post-operative days, the formation of fibrous adhesions should be prevented, since the mesothelial heals in four to seven days.

It is emphasized that there may be contraindications to the use of early feeding and to Prostigmine.

Morton, C. B. II: Postcholecystectomy Symptoms Due to Cystic Duct Remnant; Surg. 24:779, November, 1948

Among the more tangible causes for symptoms referable to the biliary tract following cholecystectomy are stone in the extrahepatic ducts, cholangitis, hepatitis, pancreatitis, errors in diagnosis, ill-advised operation, and neurogenic factors. Although a remnant of the cystic duct left at the time of operation has been recognized as a cause of biliary tract

symptoms, it has received relatively scant attention.

The author reports 7 cases, in which operation revealed a cystic duct remnant to be apparently the sole cause of post-cholecystectomy symptoms and in which removal of the remnant relieved the symptoms completely. All cases presented symptoms including pain and jaundice to such a degree that further exploration was advisable.

The operative procedure in each, in addition to general exploration and particular inspection of the liver, duodenum, and pancreas, was directed at accurate exposure of the extrahepatic ducts and careful exploration of them by probing and irrigation. The cystic duct remnant was ligated at its entrance to the common duct and excised. A T-tube was left in the common duct for drainage and decompression.

All patients have been followed at intervals from one and one-half to seven and one-half years after operation and none has had recurrent symptoms.

Mosely, V.: The Use of Tripeleannamine Hydrochloride (Pyribenzamine) as a Topical Anesthetic; The Amer. J. of Digestive Diseases, 15:410, December, 1948.

In a series of 30 patients the author has produced a very satisfactory anesthesia of the oral and pharyngeal mucosa, prior to gastroscopy, with a 1% aqueous solution of Tripeleannamine hydrochloride lasting from 45 to 90 minutes.

Each patient was instructed to agitate about in the mouth a 10 cc portion of the above solution for at least 3 minutes. Then, after a 4 to 5 minute rest period the process was repeated.

The drug has also been used with excellent results in 5 patients with very sensitive gag reflexes prior to the passage of a gastric tube; 2 patients with aphthous stomatitis who were previously unable to eat; 2 patients with acute follicular tonsillitis enabling them to take fluids and oral medications; 1 patient with a very painful carious tooth who was given immediate relief with a small amount of the drug in powdered form placed in the cavity; 2 patients with painful hemorrhoids who were treated locally with the drug in 2% strength in a water soluble ointment base.

None of the patients observed any unpleasant effects or side reactions except for a bitter taste which lasted only from 30 to 45 seconds.

The author believes this drug will prove safer than some of the now more generally used topical anesthetics.

WOMAN'S AUXILIARY

SOUTH CAROLINA MEDICAL ASSOCIATION

Your State chairman of Hygeia extends greetings and best wishes to each Auxiliary member in our State. We hope this year will be our best year for this our authentic health magazine. Hygeia has served to make the public conscious of the noble work that physicians are doing to make people well and to keep them well, notwithstanding the fact that a physician's income depends on the service he renders to people while they are ill. In other words, "Hygeia is an ambassador of good will".

I have sent a letter with all necessary literature to each County Hygeia chairman asking them to try and place subscriptions in homes, schools, libraries, doctor's and dentist offices, beauty parlors, clubs and anywhere it may be read by the public to educate them on what is true in health articles based on scientific facts, and what is false, based on theory, fanaticism, etc. May I also ask each member of the State Auxiliary to secure at least one subscription—either to place in your husbands office, or if he is already a subscriber, in another home or office?

Thanks for all your cooperation.

Sincerely,

Irene Strother Corn
(Mrs. C. P.)

TO AND ABOUT MEMBERS

Have you paid your Auxiliary dues for 1949-50? If you haven't you'll soon be hearing from your local membership chairman. During the summer a membership campaign was formulated, and your county chairman is probably hard at work right now. We want all of you back in the fold, and we have work we'd like you to help us with.

Briefly, here it is: we want more members for the Auxiliary, and you can help to get them just by dropping a good word where it's needed. Last year we had about 550 members, which was a great increase over previous years. But last year the S. C. M. A. had 1100 members. In other words, we had reached only half of our potential strength. Under our constitution doctors' mothers and daughters can have full membership along with doctors' wives, so that bachelors and widowers can be represented too. Our ultimate goal is obviously to have an Auxiliary member for each doctor in the State.

We cannot, perhaps, hope to reach the ultimate goal this year. There are still parts of our State which are not covered by a branch of the Auxiliary. Until we have groups organized for the women in these areas, we cannot expect maximum interest from them. We can, however, try to enroll them as members-at-large or associate members, and invite them to attend meetings held in neighboring counties. This will bring us nearer our goal.

In the meantime, we can all work hard within our organized areas to achieve one hundred percent of the potential enrollment. In every county there are doctors' wives who should but don't belong to the Auxiliary. Perhaps they are already overworked with duties of other organizations. Or perhaps they are just not typical club women. Most of them would be willing to join the Auxiliary if they were properly approached. And that's where you come in.

Each of you probably knows some of these women. Watch for an opportunity to enlighten them. Tell them of our student loan funds, our work with national health drives, our aims to improve health conditions in the State, our desire for increased fellowship among doctors' families, and our attempts to back up the South Carolina Medical Association in every way we can. Let them know that their passive support is of value to us. Even if they cannot now be active participants in our program, we want their names on our rolls. Their names will give us moral support, and their dues, added to the common fund, can materially increase the scope of our work.

We don't expect our members to be one hundred percent active—no organization ever attains that ideal. But we can hope to have our membership roll one hundred percent complete.

We have an organization of doctors' wives in the State working for the good of their husbands, their families, their neighbors. Membership requirements for the organization consist of payment of about five dollars a year and a desire to further the common interests at stake.

If we make clear the meaning and aims of the Woman's Auxiliary, can any doctor's wife in her right mind refuse at least to join the Auxiliary?

Mrs. John A. Seigling
Membership Chairman

STAND UP AND BE COUNTED

In line with a general movement throughout the country, the Woman's Auxiliary to the South Carolina Medical Association at its annual convention at Myrtle Beach, May 18, 1949, went on record as opposing the National Compulsory Health Insurance Program advocated by Mr. Truman in his health message to the nation. In a strongly worded set of resolutions, our State Auxiliary has vigorously condemned any political action that would rob medicine of its tried and proven system of free enterprise.

The Auxiliary to the Columbia Medical Society promptly followed the action of the State Auxiliary at its meeting on May 31, 1949 and also went on record as opposing Compulsory Health Insurance.

The advocates of socialized medicine have adopted a policy of "delayed action" for the present, giving us the opportunity to gather momentum in our crusade to preserve our cherished heritage of freedom. A swiftly rising tide of opposition to socialized medicine from organizations all over America give overwhelming proof of the desire of our people to maintain a system of private enterprise.

As of June, 1949, two important South Carolina organizations, the State Chamber of Commerce and the State Federation of Business and Professional Women's Club, as well as the State Medical Auxiliary and the Columbia Medical Auxiliary have adopted resolutions that speak out for Voluntary plans.

Wake up, County Auxiliaries!! March with the crusaders. Adopt resolutions at your next meeting to show how you stand on this vital issue. Send a copy of your resolutions to your State Legislative Chairman for her records, to the South Carolina Medical Association, to the President of the United States, to each member of the Senate and of the House of Representa-

tives from South Carolina, and to the Directors of the National Education Campaign of the American Medical Association.

The following is a copy of "A Resolution Passed at the Annual Convention of the Woman's Auxiliary to the South Carolina Medical Association at Myrtle Beach, South Carolina, May 18, 1949."

Mrs. Manly E. Hutchinson, State Legislative Chairman

Woman's Auxiliary to the South Carolina Medical Association.

A RESOLUTION PASSED AT THE ANNUAL CONVENTION OF THE WOMAN'S AUXILIARY TO THE SOUTH CAROLINA MEDICAL ASSOCIATION AT MYRTLE BEACH, S. C.

MAY 18, 1949

Realizing that needed medical and health services should be made available to every individual in the United States, and

Whereas, great pressure is being exerted on Congress to pass legislation which would place under government control the health and medical care of the people of the United States, and

Whereas, such action would undermine the personal interest, initiative, and private research on the part of the medical profession, and destroy the physician-patient relationship, and

Whereas, under a system of free enterprise the American medical profession has established the world's highest standards; thereby helping the United States to become the healthiest major nation in the world, and

Whereas, the experience of all countries where Government has assumed control of all medical services has shown that there has been a gradual decline in the health of the people, and

Whereas, we believe the most effective approach to the National health problem lies in the extension and development of Voluntary Health insurance, therefore

BE IT RESOLVED that the Woman's Auxiliary to the South Carolina Medical Association does hereby, in convention assembled at Myrtle Beach, South Carolina, May 18, 1949, go on record as opposing the Compulsory Health Insurance program now before Congress, and such bills which may be proposed, on the grounds that they are scientifically unsound, economically wasteful, and politically un-American, and

BE IT FURTHER RESOLVED that a copy of this resolution be sent to the South Carolina Medical Association, to the President of the United States, to each member of the Senate and of the House of Representatives from South Carolina, and to the Directors of the National Educational Campaign of the American Medical Association.

DEATHS

WILLIAM WARREN BOYD

Dr. William W. Boyd, 68, died at the Spartanburg General Hospital, August 11.

A native of Clinton, Dr. Boyd received his education at Wofford College, Richmond Medical College and the Medical College of the State of South Carolina (1909). Soon after he secured his degree in medicine he went to Spartanburg and practiced medicine in that city until the time of his death.

Dr. Boyd was not only a highly respected physician but a community leader and a loyal worker in the activities of his profession. He served as President of his County medical society and of his district medical society and represented his district on the Council of the South Carolina Medical Association for several years. He was respected and loved by all who knew him.

Dr. Boyd is survived by his widow, the former Miss Carolyn Felder, and two brothers.

GOVAN BRAGG HARLEY

Dr. G. B. Harley, 86 years old, died at his home in Dorchester, July 28.

A graduate of the Medical College of Chattanooga, Dr. Harley practiced medicine in Dorchester County until he retired in 1933.

Surviving are his widow, the former Miss Margaret Bell, five daughters and three sons.

HILLYER RUDISILL, JR.

Dr. Hillyer Rudisill, Jr., 47 years of age, died at his home in Charleston, July 27, after a long illness.

Born in Macon, Georgia, Dr. Rudisill received his education at Mercer University and also studied at Emory University. He was graduated from Jefferson Medical College in 1924. He moved to Charleston in

1931 from Chicago where he had been an instructor in radiology at the University of Chicago Medical School. In 1944 Dr. Rudisill accepted the position of Associate Professor of Radiology at the Medical College and Chief of the Roper Hospital X-ray department. He was forced to resign from this position in August 1948 because of ill health.

Surviving are the widow, Mrs. Helen Heard Rudisill, a son, Hillyer Rudisill, III, and a daughter, Cecily Preston Rudisill, all of Charleston.

HENRY A. WILLIS

Dr. Henry A. Willis, 47, died suddenly at his home in Moncks Corner on July 20. Although he had not been entirely well for the past few months, his death was unexpected.

Dr. Willis received his education at Clemson College and at the Medical College of the State of South Carolina (1927). He had practiced medicine in Moncks Corner since 1933.

Dr. Willis is survived by his widow and one daughter.

WALTER L. BATES

Dr. Walter L. Bates, 58, died August 11, at the Hotel Greenville where he had lived for many years.

A native of Clifton, Dr. Bates received his education at Furman University and Vanderbilt University Medical School. During World War I he served with the ROTC. He opened his offices for the practice of medicine in Greenville in 1920 and had practiced there since that time.

Dr. Bates was a member of the Greenville County Medical Association, The S. C. Medical Association and the American Medical Association. He was also an Elk.

THE EIGHTH ANNUAL ALUMNI POST GRADUATE SEMINAR

November 3 and 4, 1949

The program of the Seminar is nearly complete, and announcement is being made now so that plans to attend can be made. Based on results of the last questionnaire sent out by the secretary, several changes in the form of the program have been made which it is believed will make it more generally attractive.

The changes include: Shortening the program to a day and a half so that practitioners will not have to be away from home so long; substituting more speakers for the case presentations and round table discussions in order to cover essentially the same

ground in half the time; and including two speakers from the Medical College faculty, to enable the practitioners of the state to understand better what is going on at the College and see who makes up the institution they are supporting.

This will be the last seminar directly sponsored by the Alumni Association. Now that its worth to the College and its graduates has been demonstrated, the College has offered to take it over in the future, and the Alumni Association has voted to use its efforts and funds in other directions.

THE EIGHTH ANNUAL ALUMNI POST GRADUATE SEMINAR

BARUCH AUDITORIUM

Medical College of the State of South Carolina

November 3 and 4, 1949

Thursday, November 3rd:

9:15 A. M.—Welcoming speech; announcements.

9:30 A. M.—Faculty speaker.

10:00 A. M.—Dr. Richard H. Lyons, Professor of Medicine, Syracuse University School of Medicine: "Pathogenesis of Heart Failure and its Treatment."

11:00 A. M.—Dr. J. Englebert Dunphy, Assistant Professor of Surgery, Harvard Medical School: "The Treatment of Massive Upper Gastro-Intestinal Bleeding."

12:00 Noon—Dr. James F. Norton, Jersey City, N. J., Chief of Service, Margaret Hague Maternity Hospital: "Management of Pregnancy with Emphasis on Early Recognition of Toxemia."

1:00 P. M.—Medical College Luncheon, Library.

2:30 P. M.—Dr. Francis F. Schwenker, Professor of Pediatrics, Johns Hopkins Medical School: "The Treatment of Pneumonia in Children."

3:30 P. M.—Dr. Earle M. Chapman, Instructor in Medicine, Harvard Medical School: "Thyroid Diseases."

Evening—Founders Day Banquet. Speaker, Dr. J. R. Heller, Director, National Cancer Institute: "Current Trends in Cancer Research."

Friday, November 4th:

9:00 A. M.—Faculty Speaker.

10:00 A. M.—Dr. Howard Ulfelder, Clinical Associate in Gynecology, Harvard Medical School: "A Critical Review of Exfoliative Cytology as applied in the Diagnosis of Malignant Disease."

11:00 A. M.—Dr. Lloyd G. Lewis, Associate Professor of Urology, Georgetown University School of Medicine: "Cancer of the Genito-Urinary Tract."

12:00 Noon—Dr. T. Nelson Carey, Clinical Professor of Medicine, University of Maryland: "Diabetes."

The Journal

of the

South Carolina Medical Association

VOLUME XLV

October, 1949

NUMBER 10

Chronic Diseases Of The Thyroid

WILLIAM C. CANTEY, M. D.

E. C. KINDER, M. D.

Columbia, S. C.

The purpose of this paper is to recall to your attention some of the chronic diseases of the thyroid gland with a presentation of a representative case in each group. There is great confusion in the classification of chronic inflammatory lesions of the thyroid gland and many well known authorities believe that one type of disease will progress into another type. However, it is our intention to present to you what we believe to be three distinct clinical entities of chronic thyroiditis, and then say a brief word about carcinoma of the thyroid.

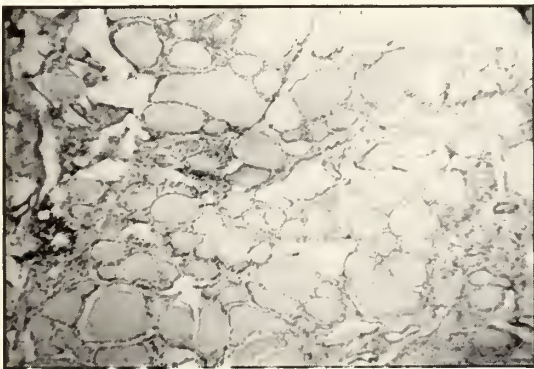


Figure 1—A colloid goitre type of tissue used to present the contrast between an approximately normal thyroid structure and the structure in the other diseases. (Dr. H. H. Plowden)

Hashimoto's Disease

The first of these groups of chronic thyroiditis is Hashimoto's disease. In 1912 Hashimoto described four cases of a relatively rare lesion of the thyroid gland characterized by a dense and diffuse infiltration of lymphocytes between the acini and the formation of secondary lymphoid follicles. This process is also known as Struma Lymphomatosa and Lymphadenoid Goitre. It is a progressive disease, possibly associated

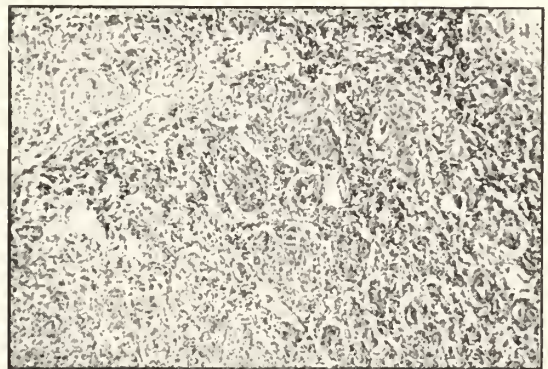


Figure 2—Hashimoto's Disease presenting almost total disappearance of the normal thyroid architecture because of widespread infiltration of vast numbers of lymphocytes and occasional plasma cells. (H. H. P.)

with a systemic disorder of a deficiency type.⁶ There is extensive acidophilic degeneration of the epithelial elements of the gland and replacement by lymphoid and fibrous tissue. The etiology is unknown. There are no single clinical or pathological features of the disease which are definitely characteristic or pathognomonic, and the entire clinical and pathological structure has to be considered in making a diagnosis. Hashimoto's disease occurs most often in women in the fourth and fifth decades, and it is rarely found in men. Dr. Crile has reported two such cases occurring in men and Dr. Marshall of the Lahey Clinic one.

The onset of the disease is insidious with no systemic reaction. There is progressive enlargement of the gland with involvement of both lobes. The gland may be slightly irregular because some areas may enlarge earlier than others giving a suggestion of an adenomatous type of goitre. Due to the enlargement there are occasionally some symptoms of pressure and rarely some pain in the gland. There is no tenderness on palpation. Occasionally, there will be early signs of hypothyroidism. The diagnosis may be suspected pre-operatively, but it is practically always made at opera-

⁶Presented before the Columbia Medical Society in January 1949.

tion. The gland is found to be firm, almost avascular, and on cut surface it is gray and somewhat resembles a hyperplastic goitre except that it is much drier than this type of gland. There seems to be a marked tendency for retro-tracheal extension, however, the gland is not adherent to the surrounding tissues. Some authorities believe that in Hashimoto's disease there are no remissions and no cures. Others are of the opinion that this lymphoid type of goitre is simply an early stage of the fibrous type of goitre known as Riedel's Struma.

McClintock² has reported a case that had two operations two and one-half years apart. The histology of the gland was unchanged at each operation. This would seem to signify that the disease was not a part of a syndrome from lymphoid infiltration to fibrosis. The character of the gland definitely resembles carcinoma in some cases and is only distinguishable by microscopic examination. If the diagnosis is known to be Hashimoto's disease, the resection of the gland should be radical enough to relieve the compression but no more of the gland than necessary should be removed. In practically all of these cases, the patient will develop some evidence of myxedema because of the loss of functional acini. X-ray therapy has been suggested and in some cases there developed clinical evidence of hypometabolism. There also is an apparent vitamin deficiency and the patients do not respond well to therapy.

Case 1—

Mrs. N. S., age 62, white, Columbia Hospital Number 31727. Was admitted on March 12, 1948 for thyroidectomy. Patient had had a large, irregular growth of her thyroid gland for five months and was sent to the Hospital for operation to relieve her pressure symptoms. The gland was bilaterally enlarged, slightly firmer than normal, irregular and without intra-thoracic extension. She had been given Iodine therapy for three months, however, on examination was non-toxic. We did not think that she had ever been toxic. At operation the gland was found to be about four times normal size in both lobes with an especially wide isthmus. During the resection it was realized that this enlargement of the gland was not adenomatous and was either some form of thyroiditis or carcinoma. With bilateral involvement, the former was decided upon. There was no frozen section. Because of the fact that the diagnosis was not realized until the operation was well under way, more of the gland was resected than probably should have been in order to relieve tracheal compression. The pathological diagnosis by Dr. H. H. Plowden was that of lymphadenoid goitre with "almost complete replacement of normal thyroid structure by vast numbers of lymphocytes." The patient made an uneventful recovery except that postoperatively there was more edema of the neck than is usual and it took several weeks to subside. At the present time this patient has not developed evidence of hypothyroidism and is apparently normal.

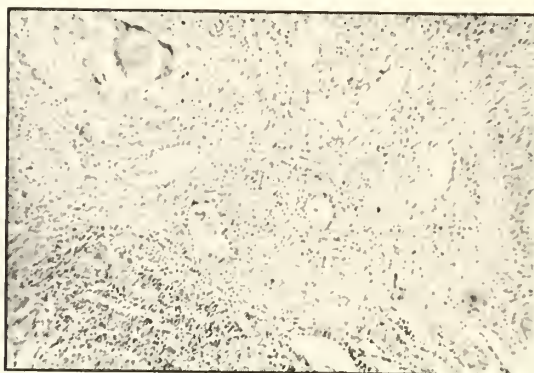


Figure 3—Riedel's Struma presenting widespread destruction of the normal thyroid architecture but with occasional preservation of a few poorly defined acini. The diffuse young fibrosis with lymphocytic and plasma cell infiltration are the outstanding features. (H. H. P.)

Riedel's Struma

In 1896 Bernard Riedel, a surgeon in Jena, presented an original report on a thyroid gland that has become known as Riedel's Struma. This paper was presented sixteen years before Hashimoto's report. Riedel described the woody hardness of the gland, the fact that it becomes adherent to the trachea and surrounding tissues with the resulting technical difficulty in its surgical removal and its great similarity to carcinoma. Riedel's Struma is a chronic, fibrous, infiltrating, inflammatory process involving one and only occasionally both lobes of the gland. The fibrosis infiltrates around the gland into the muscles, fascia and nerves producing a bulky woody-hard tumor. The true etiology is unknown. There are many cases reported where the inflammatory reaction seems to center around a degenerating adenoma. An adenoma is said to never occur in Hashimoto's disease. Marshall believes that Riedel's Struma is possibly related to the terminal or heal stage of an infectious type of thyroiditis and entirely unrelated to Hashimoto's disease. The disease occurs more frequently in women than men and in a younger age group than Hashimoto's. The onset is insidious and painless. The tumor grows slowly and it may be several years before the patient will detect its presence. There is no change in the metabolic rate unless there is total destruction of both lobes of the gland. Because of the hardness and infiltration into the capsule and surrounding tissues, the preoperative diagnosis almost always is carcinoma. Due to the absence of a natural plane of cleavage, the technical difficulties of operation are increased. The gland is almost avascular, brittle, white and cuts like cartilage, and the diagnosis is made by frozen section. The operation consists of a partial resection of the gland and especially the isthmus to relieve constriction on the trachea. The prethyroid muscles are sutured to the side of the trachea to prevent the lateral lobes encircling the trachea.⁷ The anterior part of the trachea is thereby bared. X-ray therapy has no place in the

treatment of this type of chronic thyroiditis and extensive partial removal is undesirable because it increases the incidence of post-operative myxedema.

Case 2—

Mrs. T. E. D., age 48, white, Columbia Hospital Number 19960, patient of Dr. R. G. Doughty, was admitted 4/10/47 for secondary thyroidectomy. She had had a thyroidectomy 32 years before, and now for the last year had noticed the presence of a nodule in the left lobe of the thyroid gland. This nodule had gotten much larger in month preceding admission. At operation the right lobe was found to be very small but appeared normal. The left lobe was about four times normal size, whitish, firm and fibrous looking. The diagnosis of carcinoma was entertained, however, it was decided to excise the left lobe except for a very small bit of tissue. There was no frozen section done. The isthmus was removed and the prethyroid muscles on the left side were sutured to the side of the trachea over the remnant. The pathological diagnosis by Dr. H. H. Plowden was that of Riedel's Struma. There was no evidence of malignancy. The patient had a normal convalescence and immediately postoperatively was placed on thyroid extract. In the last few months, it has not been necessary for her to continue taking thyroid extract, however, Dr. Doughty reports that there has developed another nodule in the left side of the neck. This is probably a growth of the remnant that was left at operation. There is certainly no necessity for re-operation.

Giant-Cell Thyroiditis

Into this category of thyroiditis will fall many of the non-specific chronic cases. It is also known as Pseudo-Tuberculous thyroiditis. The disease is characterized by a tender enlargement of the thyroid gland with occasionally a radiation of pain towards the ears. Fever, an elevated sedimentation rate, and other evidences of an inflammatory reaction in the neck may be present. There have been no specific organisms identified in the lesions, and a virus infection has not been excluded. The entire gland is usually involved and to palpation it is firm and occasionally irregular. The course of the disease is usually toward a spontaneous recovery without permanent loss of function of the gland. This course is shortened by thyroidectomy and/or x-ray therapy. Pathologically, there is an infiltration of leukocytes and numerous foreign body giant cells. The arrangement resembles tubercles and the disease has often been called tuberculosis. Some authorities believe that the giant cell reaction as seen microscopically represents a reaction of the wandering cells to the thyroid colloids and the resulting phagocytizing of this colloid. The cut surface is white and avascular, quite brittle and will not hold a hemostat. The capsule may be slightly adherent to the surrounding structures but there is no tendency to infiltration or fixation as is seen in Riedel's Struma. Crile has re-

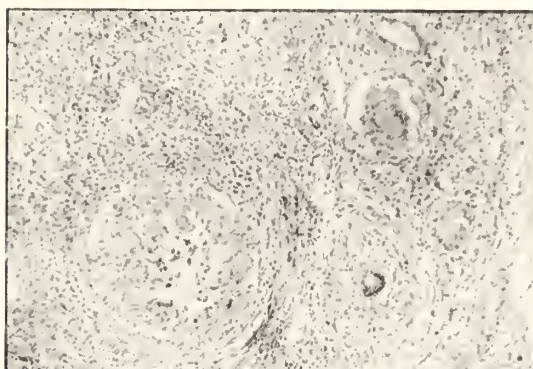


Figure 4—Giant cell thyroiditis with a lesion closely simulating miliary tuberculosis in which there are rounded miliary foci made up largely of epithelioid cells with occasional central caseation type of necrosis and the development of giant cells of the Langhans variety. (H. H. P.)

ported twelve operative cases, six of which developed a recurrence and a persistence of symptoms due to involvement of the remaining lobe. He had removed a single lobe at operation. All of these cases eventually recovered. In one case the diagnosis was made by aspiration biopsy, and x-ray therapy was given with a symptomatic cure in nine days.

The case that we are reporting as being in this category is unique in that the histological picture is one indistinguishable from tuberculosis and on one occasion the tubercle bacillus was identified from the postoperative serum in the neck. We hesitate to mention this fact because it is the second case¹⁰ on record that had tuberculosis limited to the thyroid gland with identification of the organism. Unfortunately, as so often happens there were no further specific identification procedures instituted to confirm the laboratory technician's report of the finding of the tubercle bacillus in the neck serum. We admit our failure to press the point, however, the record stands that the organism was found on a stained slide. There are many cases in the literature where the organism was found in the gland and serum along with its presence in the lymph nodes, lungs, etc.

Case 3—

E. P., age 44, a colored female, Columbia Hospital Number 8654, was admitted May 8, 1946, as a patient of Dr. A. I. Josey for thyroidectomy. The patient stated that she had noticed a "large place" in the left side of her neck for about three months before seeing her physician. There was also a choking sensation, but no pain or other evidence of an inflammatory reaction in the neck. At operation the left lobe was about three times normal size. The right lobe was normal. The left lobe was whitish, firm and appeared to be of a malignant nature. Frozen sections were not done and

it was decided to do a total left hemithyroidectomy. This was completed and the isthmus was removed. Postoperatively, there was a brawny edema of the entire neck that took about three months to subside. Serum was aspirated from under the skin flap on one occasion, and the tubercle bacillus was reported from the stained slide. There were no other evidences of tuberculosis elsewhere in the body, however, the Mantoux test was positive. Systemic recovery was normal and after the edema of the neck had subsided, the scar became soft and pliable. This patient has remained symptom free without hypothyroidism and without evidence of tuberculosis elsewhere in the body. You will note that this inflammatory involvement was unilateral, however, most of the cases in this group are bilateral. The pathological diagnosis by Dr. H. H. Plowden was that of giant cell thyroiditis. As explained above, we hesitate to label this as the second case of tuberculosis of the thyroid gland with identification of the tubercle bacillus in the post-operative serum as diagnosed by a stained slide only.

Carcinoma of the Thyroid

There is so much that can be said about Carcinoma of the thyroid for there are several common types of malignancies of the gland and most all of them act in a different way.

The commonest type of carcinoma is adenocarcinoma with its various sub-groups. It is an almost unanimous opinion that most carcinomas of the thyroid originate in a lesion which is primarily benign. It remains benign for some time and later becomes malignant, and this lesion is the discrete fetal or embryonal adenoma. It is difficult to obtain an accurate incidence of carcinoma occurring in known discrete adenomas of the thyroid, however, the general

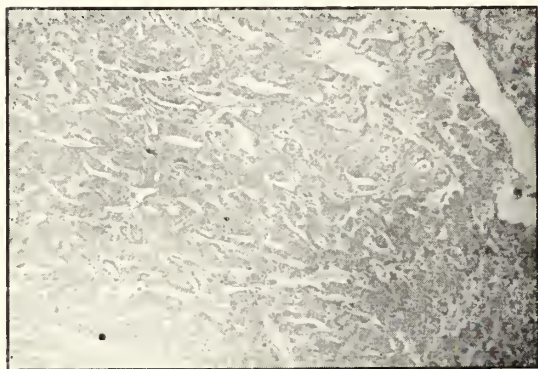


Figure 5—Carcinoma of the thyroid showing growth of typical anaplastic epithelial cells in the form of poorly defined gland tubules with complete disruption of the thyroid architecture. (H. H. P.)

average seems to be between 12 and 15 percent. We therefore believe that all discrete nodules in the thyroid gland should be removed. If the diagnosis is known to be carcinoma of the thyroid, it is necessary

to do a complete ablation of the gland. If positive nodes are present, a radical neck dissection, on the involved side is necessary. Depending upon the type of cancer and its radiosensitivity, x-ray therapy must be considered.

Case 4—

Mrs. C. W., age 63, white, Columbia Hospital Number 16926, was admitted 12/15/46 as a patient of Dr. F. E. Zemp, for thyroidectomy. In 1943 during a routine physical examination, a nodule was found in the left lobe of the thyroid gland. This nodule was completely asymptomatic and the patient elected to not have it removed. At a subsequent examination before admission, the point was pressed and she finally consented to operation. At operation a firm nodular mass of the left lobe about the size of a pecan was found. After this nodule had been completely excised including a part of the left lobe, it was bisected and because of its similarity to carcinoma a total left hemithyroidectomy was done including the isthmus. Convalescence was normal and the pathological report was that of an adenocarcinoma of low grade. The patient was then given x-ray therapy to the neck and at the present writing (two years postoperative) there has been no evidence of recurrence. There were no nodes in the neck.

Summary

1) Hashimoto's disease may be a distinct clinical entity characterized by progressive bilateral lobe enlargement of the thyroid gland, with infiltration of lymphocytes occurring practically always in women over the age of forty.

2) Riedel's Struma is probably a distinct clinical entity characterized by a chronic, fibrous, infiltrating process involving one lobe of the thyroid gland with infiltration into the surrounding muscles and fascia. The gland is hard, resembles carcinoma and occasionally results in constriction of the trachea by fibrosis. It occurs in women more often than men, and in a younger age group than Hashimoto's disease. With total destruction of the gland, myxedema may develop.

3) Another type of chronic thyroiditis has been described which resembles tuberculosis on microscopic section. The disease is characterized by a painful, tender and large gland with symptoms of pressure. The course is self-limited, and thyroidectomy and/or x-ray therapy will shorten the process.

4) Carcinoma of the thyroid gland in a large percentage of cases develops from a single discrete adenoma of the gland and it is our belief that all such nodules should be removed.

5) Cases have been reported to illustrate these various chronic diseases of the thyroid gland.

Bibliography

1. Joll, C. A., Pathology, Diagnosis, and Treatment of Hashimoto's Disease (Struma Lymphomatosa). Brit. J. Surg., 27: 351-389, 1939.
2. McClintock, J. C., Wright, A. W.: Riedel's Struma and Struma Lymphomatosa (Hashimoto); Comparative Study. Ann. Surg., 106: 11-32, 1937.
3. Graham, A., Struma Lymphomatosa (Hashimoto), Tr. Am., A Study of Goitre, 222-251, 1940.
4. Lahey, F. H., Thyroiditis, Operative Procedure for Relief of Tracheal Obstruction due to Thyroiditis, Surg., Gynec. & Obst., 60: 969, 1935.
5. Womack, N. A., Thyroiditis. Surgery, 16: 770-782, 1944.
6. Crile, Geo., Jr., Thyroiditis; Annals of Surg., 127: 640-654, April 1948.
7. Marshall, Samuel F., Meissner, William A., Smith, Delbert C., Chronic Thyroiditis, The N. E. J. of Med., 238: 758-766, 1948.
8. Stubbins, William M., Guthrie, Robert F.: Tuberculous Abscess of the Thyroid Gland, The Southern Surgeon, 14-6, P. 351, June 1948.
9. Foot, Nathan Chandler, Pathology in Surgery, Lippincott, P. 317.
10. Lauria, Henry W. and Lauria, Milton R., Tuberculosis of the Thyroid Gland; American Review of Tuberculosis, 36: 606, November 1938.
11. Plummer, W. A. and Broders, A. C.; Tuberculosis of the Thyroid, Minnesota Med., Vol. 3, 279, May 1920.
12. Rankin, Fred W. and Graham, Stephen A., Tuberculosis of the Thyroid Gland; Ann. Surg. 96: 625-646, Oct. 1932.

Attend**ALUMNI POST-GRADUATE
SEMINAR****CHARLESTON, NOV. 3, 4, 1949****See Program — Page 320**

REPORT OF THE AMERICAN ACADEMY OF PEDIATRICS STUDY OF CHILD HEALTH SERVICES IN SOUTH CAROLINA

Abstracted by J. I. Waring, M. D.

Continued from September

"In any program designed for improving the health of the people, physicians in adequate numbers are essential in the promotion of such a program. In April, 1946, there were 1079 active practicing physicians in the State. An accepted standard of adequacy of physicians is at least one physician per 1000 population. In South Carolina there are 1659 persons per active physician. In order to reach the accepted standard the number of physicians should be 1789, or an increase of 710 physicians."

"A new experiment in nurse education is under way, and before long the nation as a whole may be educating two types of nurses, one non-professional and the other professional. The non-professional training will consist of a rather short course of from nine to twelve months, which will prepare the trainee for nursing the convalescent, the chronic case and the less acutely ill. Non-professional nursing will be supervised by the professional nurse, whose education will be strengthened and extended for filling positions of nurse educator, teacher or supervisor. If this experiment proves successful and popular, the smaller schools of nursing may find it more profitable and expedient to give up their courses for professional nurses, and adopt the practical nurse program."

"According to a list of dentists published by the Division of Dental Health, State Board of Health of South Carolina, there were 323 active practicing dentists in the State as of August, 1946. The accepted standard is one dentist per 2000 population, whereas South Carolina has only 0.36 dentists per 2000 population, or one dentist for 5541 persons. In order to reach the accepted standard of adequacy 572 more dentists are needed in the State."

Included in the survey mentioned is an integrated state plan for hospital construction and utilization whereby there is proposed a co-ordinated arrangement for distribution of medical cases of varying grades of severity in the hospitals properly equipped for the desired type of service. An orderly calculation of the future needs of the state for hospital facilities has been offered. Already, since the time of the survey, many hospital beds have been added under the provisions of the Hill-Burton Act, and many more hospitals are included in

the plans for the next few years. Hospital construction or expansion completed or in process has already added 1312 beds to the number available in 1946. About 200 of these beds have been added independently of federal aid. Along with this expansion of hospital facilities goes the future enforcement of a hospital licensing law which will require certain standards for operation. This law went into effect on July 1, 1947, but the prescribed regulations have not yet been finally endorsed. However, within a short time now, it will become necessary for hospitals to come up to certain standards in order to obtain licenses.

Special Hospitals That Admit Children in South Carolina

There are four special hospitals in South Carolina which admit children. There are no hospitals for nervous or mental diseases or communicable diseases which admit children. *South Carolina Convalescent Home for Crippled Children* (Florence), operated by the State Board of Health for crippled children and rheumatic fever patients; 50 beds, 88 admissions, including 37 negro children.

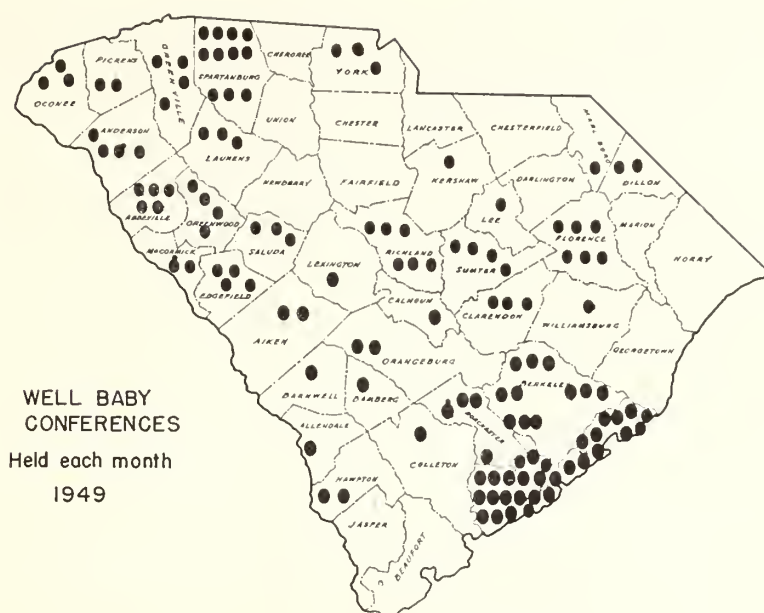
Dr. Jervey's Private Eye, Ear, Nose and Throat Hospital (Greenville), admissions 572, of which 428 were children. No pediatric service or consultation included.

Shriners' Crippled Children's Hospital (Greenville), for children only. 60 beds—198 admissions in 1946. One hundred and sixty-three patients made 989 visits to the outpatient department. Four pediatricians visited the hospital as volunteers.

State Training School (Clinton), 961 beds, including 330 for children, with only 6 children admitted in 1946. Over 500 children are waiting for admission. This institution offers essentially custodial service.

Of the five tuberculosis hospitals in the state all admitted children occasionally, but had no specialized facilities. Only one, Spartanburg County Tuberculosis Hospital, reported as much as 1,000 days of child care annually; it admitted 7 children. Only 13 children were admitted to the whole group in 1948.

Provision for the detection and care of tuberculosis in children in South Carolina is reasonably satisfactory. There are no children's ward or preventoria, but children are sometimes admitted to local sanatoria. A considerable



amount of tuberculin testing is done in the schools and during the year 1949 nearly 8,000 tuberculin tests were recorded. Facilities for taking films are well distributed. Only 5 counties of the state will lack permanent clinics for fluoroscopic and x-ray work by next year. There have been mass x-ray surveys conducted by the Division of Tuberculosis Control of the State Board of Health with the use of 3 large photofluorographic units, and with a smaller mobile unit.

Well-Child Conferences

South Carolina has relatively numerous child health conferences. During the year of the survey (1946) there were held 267 conferences for white children, 212 for non-white and 672 mixed conferences in which both white and non-white were seen, but seen in separate rooms or at different hours. At these 1151 conferences, over half of which were held in isolated rural or semi-rural counties, 2715 white, 7403 non-white and 459 patients whose race was not reported were seen. If we approximate the ratio in the last figure, we might estimate that three times as many negro children as white children were seen.

Most of these conferences were conducted by general practitioners (64.8%); the next largest segment, by health officers⁷ (24.4%); and the smallest part by pediatricians (10.8%). Of the general practitioners many probably were physicians who have had little or no specific training along the lines of child

health supervision. Practically all of the conferences (97%) offered nurses' follow-up service. About 79% offered routine inoculation against smallpox and diphtheria. Almost 85% routinely offered immunization against whooping cough. Immunization against tetanus and availability of Schick tests were not reported. Schick tests have been available since 1940, and since the time of the survey tetanus toxoid has been made available.

At these well-child conferences, there was a recorded attendance of 10,577 patients, which amounts to 35 patients per 1,000 children of the age group included (infant and pre-school). There were 49 visits per year per 1,000 children under 5, or 56% of the average number of visits for the whole country. This represents 1.4 visits per child, or 27% of the average for the whole country. However, a comforting fact is found in the figure for isolated rural counties—83 visits per 1,000—which is almost double that for counties of the United States which are in the same category.

The desirability of more frequent visits by the individual child is obvious.

As a matter of interest some calculation might be made of the medical personnel needed to cover a fairly complete program.

It may be estimated that proper provision for preventive service for individuals, both in private practice, health centers, and clinics would require the following activities for each 100 persons in each age group:⁸

⁸ Visits as estimated in *Fundamentals of Good Medical Care*, Lee, Jones and Jones, University of Chicago Press 1933.

Immunizations as estimated on current accepted recommendations.

⁷ Includes health officers, all full-time paid physicians and hospital house staff.

1. Under 1 year—850 visits annually, at least 400 immunizations.
For South Carolina, having a population under one year of 40,091, this would require the work of 45 physicians on an 8 hour, 6 day basis.
2. Ages 1 to 4—270 visits annually, at least 100 immunizations.
For South Carolina with its population in this age group of 170,569, this would require 52 physicians on the same full time basis.
3. Ages 5 to 15—100 visits annually, 100 immunizations.
43 physicians.
This would require for our state the equivalent of 140 physicians devoting their time to this activity alone.

WELL-CHILD CONFERENCE PATIENTS AND VISITS PER YEAR
PER 1,000 CHILDREN UNDER FIVE

	Patients	Visits
United States	62	182
Highest States	265	499
North Carolina	72	131
SOUTH CAROLINA	35	49
Georgia	42	128

VISITS TO WELL-CHILD CONFERENCES PER YEAR PER 1,000
CHILDREN UNDER FIVE

	Whole area	Greater metropolitan	Lesser metropolitan	Adjacent	Isolated semi-rural	Isolated rural
United States	182	422	221	65	52	44
SOUTH CAROLINA	49	0	116	42	32	83

NUMBER OF WELL-CHILD CONFERENCE SESSIONS
IN SOUTH CAROLINA IN 1945-46

Whole State	1,151	McCormick	22
County		Marion	0
Abbeville	17	Marlboro	0
Aiken	15	Newberry	0
Allendale	10	Oconee	17
Anderson	95	Orangeburg	12
Bamberg	12	Pickens	24
Barnwell	3	Richland	123 ¹
Beaufort	19	Saluda	36
Berkley	115	Spartanburg	100
Calhoun	0	Sumter	11
Charleston	219	Union	8
Cherokee	0	Williamsburg	16
Chester	0	York	16
Chesterfield	0		
Clarendon	12		
Colleton	12		
Darlington	0		
Dillon	0		
Dorchester	31		
Edgefield	48		
Fairfield	0		
Florence	21		
Georgetown	0		
Greenville	60		
Greenwood	19		
Hampton	18		
Horry	0		
Jasper	0		
Kershaw	17		
Lancaster	0		
Laurens	11		
Lee	12		
Lexington	0		

Mental Hygiene

At the time at which this survey was made facilities for mental hygiene services in children's clinics were very limited. During the year 1946 only 198 patients were seen. Of these only four were negroes. However, since that time there has been a very considerable growth in this type of work, centered about the two clinics established in Charleston and Spartanburg. During the past year (1948) there were over 2,000 visits to the Charleston Clinic alone. This clinic has a staff of 1 psychiatrist, 1 chief psychiatric social worker, 1 psychiatric social worker, 1 caseworker part-time, 1 psychologist, 1½ stenographers. The Spartanburg Clinic is much smaller, having a

¹ Includes 70 by voluntary agency; all other sessions are by official agencies.

part-time psychiatrist, full-time social worker and a clerical helper.

The procedures in the line of mental hygiene are necessarily somewhat tedious and time consuming, and therefore it is not to be expected that any complete coverage of the state can be accomplished at this time with the limited number of clinics available and the consequent difficulties of bringing children in for the considerable distances involved.

School Medical Service

School medical service has been related to the group of children from 5 to 14 years. The figures obtained are somewhat optimistically misleading as they show that only 14% of the 216,360 white children and 25% of the 193,089 colored children live in counties where school medical service is not provided in any public elementary schools. Nine counties in the state are entirely without school medical service.

These figures do not indicate in any way the completeness of medical service or the thoroughness of examination available in the schools within the rest of the counties. Under the definition used a county is considered to have available school medical service if only one public elementary school of the county furnishes examination by a physician once a year to all or selected grades, or if there is only one in which teachers or nurses refer children to physicians for examination. It is therefore, possible for a county to have extremely scanty coverage and still be rated in the desired classification. Neither do the figures give any indication of the type of medical service. It is rather well recognized that school examinations are frequently cursory, that the physicians who perform them are often not particularly well trained in such examinations, or are volunteers who may perform types of examinations quite foreign to their usual professional work, or even may be political appointees who are at best not seriously interested in developing a satisfactory type of service.

The trend everywhere is toward a rather thorough examination of a small number of children and away from the old line-up for inspection of dubiously legitimately condemned tonsils.

School examinations were carried out by 39 health officers, 19 general practitioners and not one pediatrician. Complete pediatric training is not a paramount requisite for proper examination of school children, but certainly some special consideration of the phases of medicine with which pediatrics is concerned would be a very desirable element

in those who are dealing with pediatric problems in the schools.

140 public health nurses did some school health work as part of their generalized program, and 34 nurses were employed as full time school nurses by boards of education.

School medical service in isolated areas is naturally less satisfactory than in the larger communities. Only 8 health officers and school physicians and 10 part-time nurses carried on any school work at all in the truly isolated rural counties. Two of the seven such counties were classified as lacking any school medical services of the type described above.

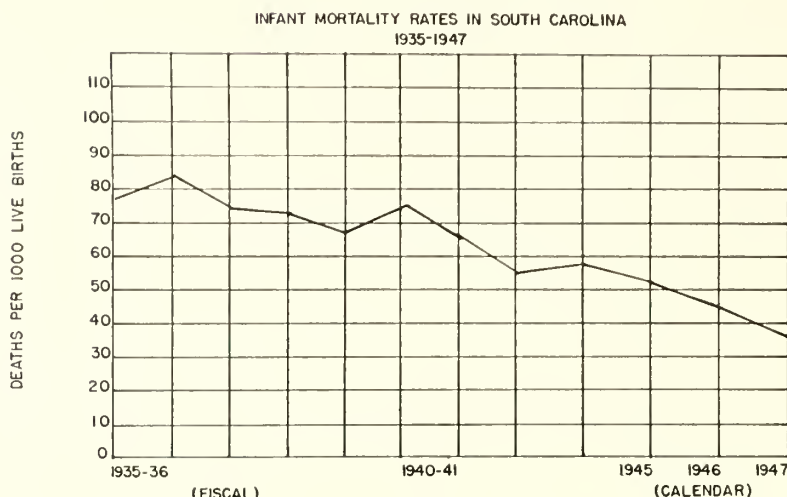
Minimal adequate supervision of the health of the school child would require at least one annual examination consuming at least 15 minutes of a physician's time. For the 409,449 school children of South Carolina, this would mean that 102,362 physician-hours should be devoted to school children alone. In order to provide this desirable service, either in private offices or in schools, 41 physicians would have to work 8 hours a day, 6 days a week the year round. However, it is generally agreed that examination of each child every year by school physicians is impractical because of limitations of available staff and therefore the estimate of needed personnel might be somewhat reduced.

Infant Mortality

During the year 1945 there were almost 50,000 live births in the state, with almost 27,000 of these white, and the rest negro (there were only 18 births of other races). Less than half of these babies were born in a hospital (49.7%). Of this group, 76% of the total white births and 14% of the total negro births were in hospitals. Over 16,000 of births were attended by mid-wives of variable capacity. In the negro group over 68% of births had no professional medical attention.

The infant mortality rate for the year was 49.9, representing the death of 2,469 infants. The neonatal death rate (that is, death in the first month of life) was 24.3% and obviously included many deaths from prematurity, malformations, and other factors which did not necessarily represent any lack of post-natal medical care. A very large part of our state's infant mortality rate is due to deaths of premature infants. In 1945 this was (and is now) the greatest single cause of infant deaths and represented over a third of the total deaths in the youngest age group.

The trend of the infant mortality rate has been downward for some years.



INFANT MORTALITY RATES

	1941-1945	1946
United States	40.7	33.8
SOUTH CAROLINA	58.5	41.4

Dental Services

Services in children's dental clinics during our study year covered a total of 8,861 patients (including very few pre-school children.) A total of 20,590 children received examinations. Considerably more than one-half (58%) of these patients were in isolated semirural counties, but none was in any of the 7 strictly isolated rural counties. The number of fillings and extractions together equalled approximately the number of prophylactic treatments. Of orthodontia there was none. This total lack of orthodontic care may be less disturbing if one is willing to consider that a very large part of orthodontic effort is toward cosmetic ends, rather than for any serious improvement in the child's health.

In dental clinics the number of visits was 1.8 per patient per year. Of each 1,000 children under 15 years of age, only 12.4 were seen during the year in dental clinics. The dentist devoted about a half hour to each child, or about 17 minutes to each visit. The number of white patients given service was more than double the number of negro patients—6060 as compared with 2303. The white children made 2.1 visits per patient per year; the negro, only 1.3.

The above statements refer to dental clinics. Over the whole state dentists saw 653 child patients in their private practice on an average day, or made about 238,000 visits a year to

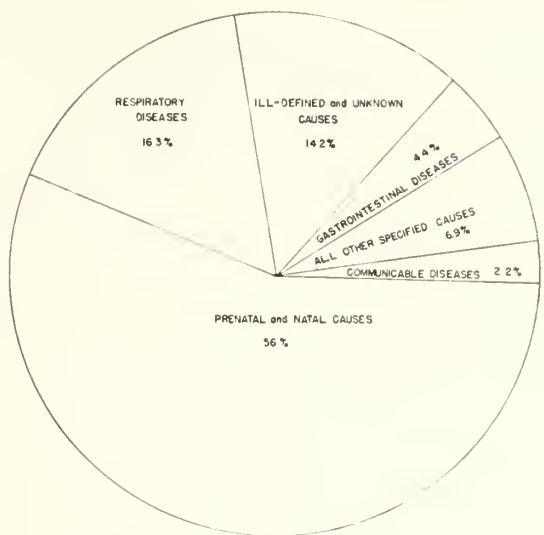
children (not individuals). These are big figures, but one must recall the 713,356 children in the state to see that dental care is not nearly as widespread as it should be.

In the field of orthodontia, the small number of visits (25 per average day by the total 4 orthodontists) indicates possibly that this type of corrective work is still in the luxury class for the South Carolinian.

Specific figures to indicate the expected need for dental care are lacking, but the Dental Division of the South Carolina State Board of Health considers that 90% of our school children are in need of dental attention. South Carolina has over 400,000 school children. 90% of this group makes an impressive number who probably require dental care, a number of children exceeding considerably the figure given currently for all dental visits.

One source¹⁰ estimates the incidence of dental illness in the group from one through 4 years at 9.1 per 1,000; in the school ages, 91.0 per 1,000. In the latter, at least one hour of dental care a year for each child is required, or 164 dentists working 8 hours a day, 6 days a week in South Carolina. The total number of dentists now in the state is 384. For the 90% of school children requiring fillings, an additional hour and a half for each would be required, and 246 more dentists would be needed to cover the demand. For complete dental care for children of the state, full services of 410 dentists would be used, or considerably more dentists than now care for the whole population.

¹⁰ *Fundamentals of Good Medical Care*, supra.



CAUSES OF DEATHS IN THE FIRST YEAR OF LIFE
PERCENTAGE DISTRIBUTION, SOUTH CAROLINA, YEAR 1947

Immunizations

Figures in the table below indicate the number of children immunized during the year by organized community agencies. These figures do not by any means represent the total number of immunizations in the state, as a very large additional number of immunizations were done by physicians in private work. The proportion of immunizations per 1,000 children must also be interpreted as covering the whole group only for the year, as many of them must have already been immunized previous to the year included in the figures and hence did not currently require immunization. On the other hand, there must be a tremendous backlog of non-immunized children as the figures indicate that with smallpox, for instance, the number of immunizations was considerably greater than the annual number of births. The whole matter of estimate of total immunizations must necessarily be somewhat vague, as in many instances the inoculations might have been repeat injections or possibly certain districts may have made much more concerted efforts to include the desired types of inoculation.

Figures obtained from certain well-child conferences (not all) indicate the efficacy of efforts for immunization in these sessions.

It should be entirely possible for the proper practitioner to secure 100% of these types of immunization and others such as tetanus in his regular office practice. Indeed the private practitioner does by far the larger part of the total immunizations. Complete figures are not available.

Physically Handicapped Children

Over 2,600 children were treated in clinics, and made 6,517 visits. Only 188 children were cared for by voluntary agencies; all the rest were handled by official agencies. There were 500 sessions of the various clinics. The Division of Crippled Children of the State Board of Health operates eight regular orthopedic clinics in various parts of the state.

South Carolina has had a physical therapy consultant since 1946, at which time the State Board of Health, through its Division for Crippled Children, created the new position.

CHILDREN IMMUNIZED BY COMMUNITY HEALTH AGENCIES
DURING ONE YEAR IN SOUTH CAROLINA

Number of immunizations reported				Immunizations per 1,000 children		
	Smallpox	Diphtheria	Whooping Cough	Smallpox	Diphtheria	Whooping Cough
Whole State	50,341	20,826	14,553	70.6	29.2	20.4

IMMUNIZATIONS GIVEN ROUTINELY IN CERTAIN MEDICAL WELL-CHILD
CONFERENCES DURING ONE YEAR IN SOUTH CAROLINA

			Children Immunized					
Smallpox			Diphtheria			Whooping Cough		
Total Patients	Number	Percent	Total Patients	Number	Percent	Total Patients	Number	Percent
982	545	55.5	1403	1060	75.6	1403	898	64.0

South Carolina occupies an unfortunately humble position in the ratings of separate services and activities which add up to the total summary of available care for children, both in the prevention of disease and in the care of illness. The state occupies the same relative position financially, and obviously our deficiencies in caring for our children link intimately with the deficiencies of our pocket-books. But the low general income of our citizens is not an insurmountable obstacle in the effort for high quality care of the younger part of our population.

It is not necessary to compare the findings of the survey with the findings in other more fortunate states, for we may as well admit promptly that we are far behind the prosperous areas of the country. It is also quite possible that the states with the best ratings are still far from the ideal possibilities for child health. However, various changes which have occurred since the time of the Academy Survey suggest that progress may be relatively rapid if sufficient interest can be aroused and kept awake.

Two organizations, the South Carolina Citizens' Committee on Children and Youth, and the South Carolina Health Council with its many local branches, have shown considerable activity and promise to do much to stimulate concern with conditions affecting children.

The matter of better distribution of physicians and dentists is an involved question which puzzles every area comprising large rural segments. Various measures, including subsidies and scholarships, have been proposed and various means of making rural practice more attractive have been suggested. Subsidies have been recommended in this state, but have never materialized. The Medical College now offers eight scholarships for students who will agree to pursue rural practice for a time corresponding to the duration of the scholarship, but there have been few applicants, and vacancies for practitioners in the sparsely populated districts are still numerous. The construction of hospitals and health centers should be a valuable inducement to de-

centralization of the supply of physicians, and in this direction progress is evident.

Since 1946 hospital construction under the Hill-Burton Act has gained much momentum. Already 1312 beds have been added to our number, and it is expected that in the next few years many more beds will have been made available. These constructions are along the lines of a well integrated long range plan, which should provide for the needs of all parts of the state by developing a system of small health centers, and community and district hospitals, with a large Medical College hospital at the apex of the pyramid. By this plan there would be available within the next few years a system including 14 health centers and 56 general hospitals.

From the pediatric standpoint, it is essential that these hospitals include adequate units for children (not scattered beds), and that improved arrangements be made for newborns in general and premature infants in particular. Indeed the need of a concerted drive against the deaths among premature babies is urgent if we are to reduce our infant mortality rate. It is to be expected that the Hospital Licensing Act, which became effective July 1, 1947, will do much to improve conditions in older structures and provide better accommodations in the new buildings.

One outstanding point of the survey is the indication that the general practitioner takes care of 75% of our children, and that his preparation for such work is generally inadequate.

Pediatricians themselves are often lacking in substantial pediatric training. The remedy should lie in providing more basic training in pediatrics in medical schools, and in making available to all practitioners the benefits of postgraduate education. Most medical schools are finding difficulties in securing adequate financial support, and most pediatric departments are limited in budget and scope. Considering the large amount of pediatric work which will be included in the practice of the graduates, anyone interested in improving the

medical care of children would at once understand the necessity of raising pediatric departments to positions of great importance in respect to time allotted for teaching and to size of staff. Even though positions have been created recently for three teaching fellows, the pediatric department of our own Medical College is still relatively small and limited in its field.

For postgraduate study we might well encourage the more general use of such available facilities as the Pediatric Seminar at Saluda, North Carolina, and potential courses which might be provided in various parts of the state by the Medical College, or offered as postgraduate seminars in Charleston. To provide such opportunities the College would necessarily require a larger pediatric staff and more money with which to employ it.

It would be logical to require that physicians who are employed in health conferences, school work, and similar activities be encouraged or required to secure some technical pediatric instruction in the type of examination which they do, and that demonstrations or institutes be made available to them.

Improvement in the type of examination of school children might no doubt be accomplished by local interest and pressure. The

opportunity in this state for improvement is large. The bill in Congress providing assistance in the diagnosis and treatment of defects in school children should do a great deal, not only toward bettering the physical condition of many children, but also in setting standards of proper types of examination.

Much can be done to direct interest to the problems of child health. With sufficient public concern will come improvement in our present unsatisfactory conditions. The many interested organizations might well be informed, encouraged, and led by a Committee on Child Health of the South Carolina Medical Association, which would be the proper body to organize a systematic program. At present no such committee is functioning. The constant and productive activity of the Division of Maternal and Child Health of the State Board of Health has done much to improve the situation in the field of public health over past years, and the Division is eager to further any efforts toward the goal of making available to children the full benefits of modern medical care. Under the existing arrangement whereby the State Medical Association is, in effect, the Board of Health, cooperative activities between a Committee on Child Health and the Division of Maternal and Child Health could be readily encouraged and actively pursued.

CHILD POPULATION, BEDS IN GENERAL HOSPITALS AND PRIVATE PRACTITIONERS
BY COUNTIES IN SOUTH CAROLINA

State and County	County group ^o	Population 1945 Children under 15	Beds in general hospitals	Private Practitioners, 1946					
				No. of Physicians		No. Per 1000 Children			
				Total	General practitioners	No. of dentists	Physicians	General practitioners	Dentists
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
S. Carolina	X	713,356	4,686	967	712	331	1.36	1.00	0.46
Abbeville	4	7,340	34	9	8	4	1.23	1.09	0.54
Aiken	3	18,474	65	23	21	7	1.25	1.14	0.38
Allendale	5	4,867	0	6	6	3	1.23	1.23	0.62
Anderson	4	29,770	188	53	39	14	1.78	1.31	0.47
Bamberg	4	7,442	0	9	9	3	1.21	1.21	0.40
Barnwell	5	7,533	0	8	8	4	1.06	1.06	0.53
Beaufort	4	8,057	92	10	10	2	1.24	1.24	0.25
Berkeley	3	11,986	75	7	7	1	0.58	0.58	0.08
Calhoun	3	6,277	0	6	6	1	0.96	0.96	0.16
Charleston	2	55,685	627	94	50	38	1.69	0.90	0.68
Cherokee	4	11,457	58	6	5	7	0.52	0.44	0.61
Chester	4	10,911	50	9	8	5	0.83	0.73	0.46
Chesterfield	4	13,756	0	12	12	5	0.87	0.87	0.36
Clarendon	5	13,948	0	8	8	1	0.57	0.57	0.07
Colleton	3	9,976	54	11	10	5	1.10	1.00	0.50
Darlington	4	18,777	70	12	12	5	0.64	0.64	0.27
Dillon	4	11,896	42	10	9	3	0.84	0.76	0.25
Dorchester	3	9,414	49	9	9	3	0.96	0.96	0.32
Edgefield	5	6,504	0	5	4	5	0.77	0.62	0.77
Fairfield	3	8,179	14	6	6	4	0.73	0.73	0.49
Florence	4	29,199	196	48	37	14	1.64	1.27	0.48
Georgetown	3	12,426	0	9	9	4	0.72	0.72	0.32
Greenville	4	44,496	505	104	65	31	2.34	1.46	0.70
Greenwood	4	12,720	115	20	17	10	1.57	1.34	0.79
Hampton	5	6,777	0	8	8	1	1.18	1.18	0.15
Horry	4	23,038	82	17	15	3	0.74	0.65	0.13
Jasper	3	4,311	38	2	2	1	0.46	0.46	0.23
Kershaw	3	12,394	70	13	12	5	1.05	0.97	0.40
Lancaster	3	11,956	63	9	7	4	0.75	0.59	0.34
Laurens	4	13,710	73	17	17	6	1.24	1.24	0.44
Lee	4	9,785	0	7	7	2	0.72	0.72	0.20
Lexington	3	13,085	15	7	7	3	0.54	0.54	0.23
McCormick	5	3,798	0	2	2	1	0.53	0.53	0.26
Marion	4	11,411	102	18	16	4	1.58	1.40	0.35
Marlboro	4	12,870	72	15	13	5	1.17	1.01	0.39
Newberry	3	10,687	62	15	13	5	1.40	1.22	0.47
Oconee	4	12,986	42	12	12	7	0.92	0.92	0.54
Orangeburg	4	24,828	136	29	19	9	1.17	0.77	0.36
Pickens	4	13,231	20	12	12	3	0.91	0.91	0.23
Richland	2	34,147	735	117	56	39	3.43	1.64	1.14
Saluda	5	5,696	0	4	4	2	0.70	0.70	0.35
Spartanburg	4	44,454	470	86	49	27	1.94	1.10	0.61
Sumter	3	21,836	163	25	16	7	1.15	0.73	0.32
Union	4	11,018	44	10	10	4	0.91	0.91	0.36
Williamsburg	4	19,940	89	15	14	4	0.75	0.70	0.20
York	3	20,308	176	33	26	10	1.63	1.28	0.49

^oCode: greater metropolitan 1, lesser metropolitan 2, adjacent 3, isolated semi-rural 4, and isolated rural 5.

**TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION**

1949

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

**MEETINGS
WHICH ANY PHYSICIAN
WOULD DO WELL TO ATTEND**

**ALUMNI POST-GRADUATE SEMINAR
CHARLESTON,
NOV. 3, 4**

**SOUTHERN MEDICAL ASSOCIATION
CINCINNATI,
NOV. 14-17**

**AMERICAN MEDICAL ASSOCIATION
CLINICAL SESSION
WASHINGTON,
DEC. 6-9**

The Journal of the South Carolina Medical Association

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Florence, S. C.

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OCTOBER, 1949

CHILD HEALTH SERVICES

Under the sponsorship of the American Academy of Pediatrics a nationwide study of child health services has been made. The study in South Carolina was carried out under the general chairmanship of Dr. William Weston, Jr. with Dr. Henry Moore serving as executive secretary. The data obtained has been compiled and edited by Dr. J. I. Waring and the completed study has been published in this Journal, the first installment in the September issue and the second and final installment in this issue.

The study presents both a picture and a challenge. Here are some of the salient points which should provoke careful thought on the part of those who are planning the future activities of our Association and of our Medical College:

Since something over eighty percent of the babies of the state receive their medical care from general practitioners it is essential that these physicians be well trained in the problems of child care. The study shows that such training is not now being given and suggests more pediatric instruction to our medical students and also more post-graduate training to those in practice. High praise is given to the Southern Pediatric Seminar at Saluda for the work which it is doing toward giving such pediatric training. The study also indicates that the pediatricians themselves would do well to secure more post-graduate training in their particular field. It also shows that physicians and nurses in the various health departments are dealing with more and more children and that they too should have more adequate training in pediatrics.

An appraisal of the hospital situation shows a real need for more beds for the newborn, for premature babies, and for contagious diseases. Other needs are—more nurses for child care, more physicians in schools, a concerted drive for the better care of premature babies, better dental care for the indigent, and more physicians in the more rural areas. One startling fact is that 17% of infants who died, died without the benefit of medical care—whether this was due to in-

ability to secure the services of a physician or whether it was due to indifference or ignorance on the part of the parents, is not determined.

All in all, the study should give each member of the Association ample food for serious thought. If our Association is to lead the people of the state in planning for better medical care it should heed well the facts brought out and the recommendations made by this study.

AUTOMOBILE EMBLEMS

A new supply of automobile emblems has been received and are available for purchase from the Secretary. These emblems are similar to those available in the past and show the letters M. D. in the center with the legend, South Carolina Medical Association, around the border. Only members of the Association may purchase them and no member may purchase more than two.

The cost of the new emblems is \$3.25 and those who order them are requested to send a check with the order, to obviate extra bookkeeping.

BLUE SHIELD PARTICIPATION

Before the South Carolina Medical Service (Blue Shield) Plan can be put into operation, fifty percent of the registered physicians in the state must sign an agreement to participate in the plan. Since there are quite a number of physicians in the state who are not members of our Association, this means that approximately sixty percent of our membership must "sign up."

The South Carolina Medical Service Plan is our own project. A special committee worked out the details, our House of Delegates set up the necessary foundation upon which to build.

Effort is now being made to have physicians agree to participate in the plan. When any member of the Association is asked to place his name on the agreement he might well ask himself this question, "Do I

favor a plan in which I am a stockholder, a plan in which I can have a voice as to its operation, or shall I wait and let the federal government establish a plan and treat me as a pawn?"

AN IMPORTANT LETTER

Dear Fellow Alumni:

In announcing the program for the Alumni Post Graduate Seminar the Committee calls your attention to certain radical changes.

Before each annual session the Committee has sent cards and inquiries to the Alumni requesting criticism and suggestions. We have adapted as many of the suggestions as possible into the 1949 arrangements.

1. For the first time Speakers from the Faculty of the Medical College will be on the program.
2. The Seminar has been shortened to one full day—Founders' Day, and one-half day following Founders' Day.
3. Although the time element has been curtailed more speakers are being presented each day. Dr. John M. Boone, Assistant Dean and Faculty Advisor to the Seminar has done an excellent job in securing most capable speakers.
4. We have attempted as far as possible to act on your suggestions as to subject matter. We are presenting topics of prime interest to the General Practitioner. I feel sure that a glance at the subject matter to be presented will reveal presentations of common interest.
5. Social program has been virtually eliminated. On Founders' Day the Medical College will present its usual delightful luncheon to all attending the session. The Founders' Day Banquet will feature a South Carolinian,—Dr. J. R. Heller who will speak on a subject of highest interest.

This is the last of the Seminar to be presented by the Alumni Association per say. In 1950 the Medical College will assume responsibility for the Seminar.

We urge every Alumni to support and attend the Alumni Seminar.

Most Fraternally yours,
Chairman, Post Graduate Com.
D. Strother Pope, M. D.

PROGRAM

ALUMNI POST GRADUATE SEMINAR

November 3, 4, 1949

BARUCH MEMORIAL AUDITORIUM

Charleston, S. C.

Thursday, November 3

9:15 A. M. Welcome, and Announcements

9:30 A. M. Faculty Speaker of the Medical College of South Carolina to be announced.

10:00 A. M. Dr. Richard H. Lyons—Professor of Medicine, Syracuse University. Medical Subject.

11:00 A. M. Dr. John E. Dunphy, Assistant Professor of Surgery at Harvard. "THE TREATMENT OF MASSIVE UPPER GASTRO-INTESTINAL BLEEDING."

12:00 A. M. Dr. James F. Norton—Assistant Clinical Professor P & S, Margaret Hague Hospital. Obstetrical Subject.

1:00 P. M. Luncheon Medical College Library

2:30 P. M. Dr. Francis F. Schwentker, Professor Pediatrics, Johns Hopkins. "TREATMENT OF PNEUMONIA IN CHILDREN."

3:30 P. M. Dr. Earle M. Chapman, Instructor of Medicine, Harvard. "THYROID DISEASES." Founders' Day Banquet—Dr. J. R. Heller, Chief of Cancer Division U. S. Public Health Service. "CURRENT TRENDS IN CANCER RESEARCH."

Friday, November 4

9:00 A. M. Faculty Speaker to be announced later.

10:00 A. M. Dr. Howard Ulfelder, Clinical Associate, Gynecology, Harvard. "THE CRITICAL REVIEW OF EXFOLIATIVE CYTOLOGY AS APPLIED IN THE DIAGNOSIS OF MALIGNANT DISEASES."

11:00 A. M. Dr. Lloyd G. Lewis, Associate Professor, Urology, Georgetown University. "CANCER OF THE URINARY TRACT."

12:00 A. M. Dr. T. Nelson Carey, Clinical Professor of Medicine at the University of Maryland. "DIABETES."

V. D. R. L. Slide Test

The Division of Laboratories with the approval of the Executive Committee of the State Board of Health will in the near future replace the Mazzini Slide Flocculation (qualitative and quantitative) test with the Venereal Disease Research Laboratory Slide test in the serologic diagnosis of syphilis.

The VDRL slide test uses a cardiolipin antigen and embodies all the advances and advantages of cardiolipin antigens. Please note that, in contradistinction to the Mazzini, where a two-plus reaction is considered *doubtful*, a two-plus reaction with the VDRL slide test is considered *positive*.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

BLUE SHIELD ADOPTS CONTRACTS, FIXES RATES

The Board of Directors of the South Carolina Medical Care (Blue Shield) Plan, meeting in Columbia on September 14th, took important action toward starting operation. Reports of Committees which had been working on essential phases of the program were received, subscription rates fixed and the forms of contracts adopted.

The Committee on Subscription Rates, after intensive investigation and acting upon the advice of actuaries familiar with the operation of non-profit Medical and Hospital Care Plans, presented to the Board a full report on the subject. On the basis of the experience of other Plans as to the incidence of various surgical procedures among members, the Board fixed initial rates for the South Carolina Medical Care Plan of \$.85 per month for individual member contracts and \$2.25 per month for family contracts.

In arriving at these rates the number of Blue Cross Contracts in South Carolina on March 31, 1949 was taken as a guide toward the reasonable potential distribution of contracts in the Blue Shield Plan. The rates adopted are sufficiently in excess of the minimum rates recommended by the actuaries to provide necessary revenue, to furnish a reasonable margin for safety. In addition to the estimated cost of actual benefits to be provided by the Plan, approximately 30% of the entire subscription charge is included to provide for cost of administration and to establish a reserve.

The Board considered carefully and gave its approval to forms of the Subscriber Contract and the Agreement between the Plan and the Participating Physician. Both of these contracts, in the form approved by the Board, are printed elsewhere in this issue for the information of the members of the South Carolina Medical Association. It is possible that some minor changes may be made in the Subscriber Contract before final printing of the forms preparatory to the beginning of the Plan's operation. This is essentially, however, the Contract that will be sold to Subscribers, and in all probability there will be practically no change.

The form of Agreement between the Plan and Participating Physician has been adopted finally and the Committee in charge of Physician Enrollment, Dr. W. Wyman King of Batesburg, Chairman, is proceeding with the work of securing signatures. Dr. King's Committee likewise reported to the Board and its plan of procedure was approved. Copies of the fee schedule and the form of Agreement between the Plan and Physician are in the course of preparation

as this is written and are expected to be mailed to all physicians in the State within the next few weeks.

It will be recalled that under the terms of the Act, at least 50% of the practicing physicians in the State must be enrolled as participants before the Plan can operate.

The Finance Committee, Dr. J. Howard Stokes of Florence, Chairman, reported the availability of \$10,000.00 as initial capital, this amount having been furnished by the South Carolina Medical Association as a non-interest bearing loan to the Plan. Further studies are in progress to determine whether or not it would be advisable to raise additional funds to add to this amount. The Committee was authorized to take such steps as it sees fit to obtain the necessary additional amount in the event that appears to be necessary or advisable.

The Liaison Committee, Dr. George D. Johnson of Spartanburg, Chairman, reported the results of a joint meeting of his Committee and a similar group appointed by the Board of Directors of the Blue Cross Plan, toward an arrangement for the sale, promotion and advertising of Blue Shield, and its general Administration by the Blue Cross Plan. Under the terms of this arrangement, initial costs of Blue Shield printing and the additional administrative cost for personnel, office and other necessary expense of the Blue Cross Plan for the first sixty days will be paid by the South Carolina Medical Care Plan. At the end of that period an effort will be made to work out on a percentage basis the share of the total administrative cost to be borne by Blue Shield thereafter. The report of the Committee was well received and Dr. Johnson and his group were commended by the Board on the tentative arrangements thus made. If, as expected, similar approval is given by the Board of Directors of Blue Cross, the foregoing appears to be the basis on which the administrative work of Blue Shield will be commenced. Mr. Allen D. Howland, who has been employed for the past several years as Executive Director of the South Carolina Hospital Service (Blue Cross) Plan, was elected by the Board to serve in the same capacity for the South Carolina Medical Care Plan.

The Central Professional Service Committee, Dr. C. R. F. Baker of Sumter, Chairman, reported preliminary studies relative to its duties. This is a standing Committee whose work is concerned with the actual day to day operation of the Plan, rather than with preliminary matters preparatory to its operation.

It is the expressed hope and the intention of the Board to have all plans and arrangements perfected sufficiently in advance to begin operation and the sale of contracts to Subscribers by the first of the coming year.

THE HIGH COST OF FREE MEDICAL CARE*

(Editor's Note: Many estimates have been made on the probable cost of National Compulsory Health Insurance in the United States. These have varied widely over an area of millions of dollars, depending generally upon the viewpoint of the individual making the estimate. Actually, and this is generally admitted, it is impossible to approach with any degree of certainty a correct estimate of what that cost would be. The facts and figures contained in the following article by Richard Denman, a London Economist, reprinted from the "American Druggist" of July, 1949 may give us, by comparison with the experience in that country, some idea of what may be expected here if the system is adopted.)

The one aspect of the health service that has never received the attention it deserved is its cost. Therefore, the average citizen knows very little about the cost, and even less about how it can be paid by the British people.

In the Beveridge Report, it was estimated at £170 million (\$680,000,000); at the time the National Health Service Bills (one for England and Wales and one for Scotland) were before Parliament, at £174 million (\$696,000,000); and for the first nine months of operation, from July 5, 1948 to March 31, 1949 at £198 million (\$792,000,000).

Nobody, however, paid much attention to the question of what the actual cost was likely to be. Few people, in fact, bothered very much about whether the state had assumed a liability it could not afford. "We cannot afford not to have it" was the stock, and glib answer if anyone had the temerity to question whether a National Health Service could be afforded.

Yet, what happened when the Health Service came into force last July was a big rush for spectacles, for dental treatment and for doctors' services. The overall demand for hospital beds had always been greater than the supply so that the effect of the Health Service on the hospitals was not so immediately apparent. General practitioners are paid a capitation fee per patient on their lists, which remains the same however much or little they work, so that the cost of their services could be estimated fairly accurately in advance. But where payment is made by items of service, as is the case with dentists, opticians and chemists, the estimates fell wildly under the mark, as is shown in the following table:

IN MILLIONS: POUNDS AND DOLLARS

	Estimate	Spent July 5, 1948 March 31, 1949
General Practitioners' Service	31,500 (\$126,000)	33,800 (\$135,200)
Ophthalmic Service	2,330 (\$ 9,320)	14,970 (\$ 59,880)

*Reprinted from the "American Druggist" issue of July, 1949.

Pharmaceutical Service	12,700 (\$ 50,800)	17,715 (\$ 70,860)
Dental Service	8,150 (\$ 32,600)	21,800 (\$ 87,200)
Hospital Service	120,606 (\$482,424)	145,077 (\$580,308)

In spite of this underestimate, the Government's estimate for these services in the current year 1949-50 shows in some cases a slight reduction, if allowance is made for the fact that it covers a full year instead of nine months.

IN MILLIONS: POUNDS AND DOLLARS

	Spent 1948-49 (on annual basis)	Estimated 1949-50
General Practitioners' Service	45,063 (\$180,252)	45,800 (\$183,200)
Ophthalmic Service	19,960 (\$ 79,840)	13,890 (\$ 55,560)
Pharmaceutical Service	23,620 (\$ 94,480)	20,490 (\$ 81,960)
Dental Service	29,033 (\$116,132)	31,004 (\$124,016)
Hospital Service	193,436 (\$773,744)	202,002 (\$808,008)

Will demand lessen?

The Minister of Health is assuming that a large part of last year's demand was accumulated and will not continue at the same level. This may be true of the demand for spectacles, and to a smaller extent of the central service, but it cannot be assumed for any other part of the Health Service. The truth is that there is a virtually unlimited potential demand for medical services, whether they are provided by the state or from private sources. (Before the war, it was estimated that private payments to doctors and dentists were about £50 million (\$200,000,000) which would be about £90 million (\$360,000,000) at present prices.) When these services are provided privately, the potential demand is checked by the amount that the individual can afford to pay from his own pocket. What happens when the state undertakes to pay the doctor's bills Great Britain is at present finding out. Where possible, the brake is placed not on the demand, but on the supply; that is, an attempt is made to allow the different branches of the Health Service to spend a certain amount and no more. Thus the hospitals have had cuts imposed on the budgets they had drawn up for their expenditure in the current year, with the result that many beds have had to be closed. Where payment is made by items of service, it is more difficult to place a check; if the demand continues to outrun expectations, the only means of checking the amount spent, if the service continues to be "free," is by cutting practitioners' fees—as indeed already has happened to dentists and opticians.

General tax pays 78%; Health Insurance only 12%

In Great Britain, the natural demand for the Health Service is stimulated by public misconception about how it is paid for. It was introduced at the same time as the National Insurance Scheme, and since the former panel, medical service had been largely paid for out of insurance contributions. There has, therefore, been a tendency to make use of the Health Service "to get some of my money back." In fact, however, as the Ministry of Health has often pointed out, by far the greater part of the cost of the Health Service is met from taxation. Only 8½d. (\$.17) from a man's total national insurance contribution of 4s. 11d., (\$1.02) and 6½d. (\$.13) of a woman's contribution of 3s. 10d., (\$.80) goes towards the cost of the Health Service. Put in another way, 17s. 6d. (\$3.52) of every £1 (\$4.03) that is spent on the Health Service is paid for by taxation; only the remaining 2s. 6d. (\$.52) comes out of the insurance contributions.

Cost vs. indirect taxes

The total cost of the Health Service to the taxpayer, that is, after allowing for the payment made towards it from the insurance contributions, including the services provided by local authorities and other items, is estimated at £263 million in the present financial year. This is equal to about £5.4s.0d. (\$21.00) a person or £20 (\$81.00) for each of the 13 million families in the country. It is not, of course, possible to say that this expenditure is met by such and such a tax. It is met out of the general body of revenue which is roughly divided equally between indirect taxation, paid by everybody, and direct taxation which is steeply progressive.

Beer tax equals Health Service cost

The yield from the tax on beer, for instance, is roughly equal to the cost of the Health Service; but this does not mean that if there were not a Health Service to be paid for, there would be no tax on beer. Similarly, the cost of the Health Service is roughly equivalent to 2s. (\$.40) in the standard rate of income tax. If income tax were reduced by this amount, it would be a saving in the income tax burden of a man, with three children and earning £2,000 (\$8,000) a year, of which £114 (\$456.) would more than compensate him for his medical bills—he is quite likely remaining outside the Health Service and continuing to pay his doctor privately in any case. But here again, it would be wrong to assume that if there were no Health Service, the standard rate of income tax would be reduced by 2s. (\$.40). All one can say is that the general burden of taxation would be reduced by £263 million (\$1,052,000,000) and how this relief would be allocated between indirect taxation, which presses most hardly on the lower income groups, and direct taxation which presses most on the

higher income groups, which depend on the mood and views of the government of the day. The sequence is here to stay but such a complete reversal is not to be expected. Some form of government Health Service has come to stay, whatever party is in power.

Home modification only hope

The only hope of any reduction in the cost is in home modification. In his budget speech, Sir Stafford Cripps spoke of the possibility of imposing a special charge if the public could not be brought to use the Health Service responsibly and sensibly, although he gave no indication of how this would be raised.

It is just possible, too, that if the cost of a Health Service rose to more than the country could afford, people might be required to pay directly some part of the cost—for instance, a proportion of the cost of spectacles or a token payment for their maintenance in hospital. This, however, is pure speculation.

At the moment, all that can be said is that the Health Service is costing far more than was estimated, that there is constant pressure to make it cost still more, and that the limit of what the Government can raise in taxation to meet it has already been reached. No one knows what will happen when the people comprehend the cost of the existing social services.

AGREEMENT

Between the

SOUTH CAROLINA MEDICAL CARE PLAN

and the

**PARTICIPATING PHYSICIAN NAMED
HEREIN**

THIS AGREEMENT, Made the _____ day of _____, 19____, by and between the South Carolina Medical Care Plan, herein called the "Plan," operating a prepayment plan for professional service to the public, and _____, a physician, duly licensed to practice medicine and/or surgery by the State of South Carolina, herein called the "Participating Physician," WITNESSETH as follows:

1. In consideration of the benefits accruing to him under the Plan, the participating physician agrees to furnish professional service to the subscribers of the Plan in accordance with his license to do so, and in accordance with the terms and conditions of the subscriber's certificate.
2. The participating physician agrees to observe all of the rules and regulations of the Plan as provided in the By-laws and otherwise, and any and all amendments thereof. The physician may decline however, to accept a subscriber as a patient, in strict accordance with his present rights and practice.
3. The Plan agrees to pay the participating physician



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has been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for the prophylactic and therapeutic relief of motion sickness.

*TRADEMARK OF G. D. SEARLE & CO.



for his services, rendered to subscribers to the Plan and their covered dependents, in accordance with the terms and conditions of the subscriber's certificate, and in accordance with the usual and customary charges of the participating physician for such services, but not in excess of the amounts provided and stipulated in the schedule of fees adopted and approved by the South Carolina Medical Care Plan May 17, 1949, and any changes therein made as provided in the By-laws of the said Plan.

4. It is understood that this agreement does not provide for payment to the participating physician except as set forth in the subscriber's certificate and the schedule of fees and any changes hereafter made therein as provided in the By-laws; that payment will be made only for those services so provided and falling within the range of the training and experience of the participating physician—emergency aid excepted; that full cooperation will be extended to the Plan in determining the subscriber's eligibility for services and that the Plan's decision as to such eligibility shall be final and conclusive.
5. The participating physician, immediately upon discharge of a subscriber-participant from the hospital, or following the performance of a service, shall render to the Plan a statement of services, on proper forms, at the charge provided under the terms of the fee schedule then in effect. Financial settlement between the Plan and the participating physician shall be made monthly except in cases requiring individual consideration, settlement for which shall be made quarterly.
6. It is understood and agreed that compensation by the Plan to the participating physician shall not exceed the fees provided in the schedules of the Plan.
7. In the event the rates charged to subscribers by the Plan prove to be insufficient to make the Plan self-sustaining, and in order that the Plan may keep faith with its subscribers until such time as rates, or benefits, may be properly adjusted, the participating physician agrees to furnish services to the subscribers during the period of this agreement when and as necessary even though a reduction in the payment for the scheduled items is necessary. Any reduction or delay in payment for the services shall be without prejudice to the subscriber's rights to such service. The determination of this ability to pay, and the right to reduce and increase payments shall be made by the Plan's Board of Directors in its sole discretion. Notice of such action will state the effective date of adjustment and will apply to all bills received after such effective date, and until the reduction or increase in payments is repealed, modified, or amended. If and when the financial condition of the Plan, in the opinion of the Plan's Board of Directors, reaches a point where all, or a pro rata part of, reductions can be returned to the participating physician, this will be done by action of said Directors. The determination of all the actions herein outlined by the Plan's Board of Directors shall be final and no legal action shall be instituted as a result thereof.
8. It is specifically agreed by the participating physician that:
 - (a) If the subscriber's total annual income combined with the total annual income of members of his family entitled to qualify as covered dependents under the family contract of the Plan, is less than Thirty-five Hundred (\$3,500.00) Dollars at the time the service is rendered, the participating physician will make no charge in excess of the amount provided in the fee schedule for the particular services performed, and he agrees to accept the fees so specified in the fee schedule as the same may be amended from time to time, in accordance with the By-laws, in full payment for his services.
 - (2) If the subscriber's income combined with the income of members of his family entitled to qualify as covered dependents under the family contract of the Plan, is Thirty-five Hundred (\$3,500.00) Dollars or more at the time the service is rendered, the participating physician will allow, without recourse to the patient, the fee outlined in the fee schedule, as a credit on his regular charge for the services rendered and will look to the subscriber for payment only of any amount due in excess of such scheduled fee. This provision shall be applicable at all times, including such instances as may arise under the provisions of Paragraph 7 of this agreement.

Income is defined as gross salary, if employed by another; and as net income, after ordinary and necessary business expenses, if the subscriber is self-employed.
9. It is understood and agreed by the participating physician that he consents to, and will abide by the majority decision of the Central Professional Service Committee of the Plan, in the event of any dispute arising hereunder. This Committee is authorized to adjust all matters in dispute between the parties hereto and the physician hereby agrees to be bound by the decision of said Committee as to matters arising both between the participating physician and the Plan, and between the physician and subscribers to the Plan or their covered dependents.
10. The term "subscriber," wherever used herein, is understood and shall be interpreted to include, where applicable, the regularly covered dependents of subscribers duly enrolled. The term



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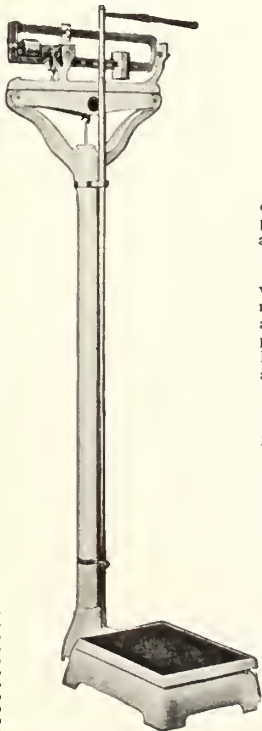
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SPECIFICATIONS:

Standard Finish: Oven baked white enamel
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permanent service. Novel dial construction
of the airplane type dial makes it ex-
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lb. Space required 11 x 16 inches.

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"covered dependents," wherever used herein, is understood and shall be interpreted to mean those dependents of a subscriber who are entitled to qualify for professional services from participating physicians with the Plan under the terms of its family contract, as provided in the By-laws and regulations.

11. This agreement shall continue indefinitely unless one of the parties expressly desires to terminate it as hereinafter set forth. Either party may terminate this contract, termination to be effective at the end of any calendar month, by delivering notice in writing of his or its intent to so withdraw, to the other party not later than thirty (30) days before the date upon which such termination is to become effective. However, if the participating physician shall terminate this agreement, such termination shall be without prejudice to any prior claim or claims incurred in whole or in part, on the effective date of such termination and shall not relieve the participating physician of his obligation to render service to subscribers and their covered dependents for a period not to exceed three (3) months from date of termination; and the participating physician shall be entitled to receive from the Plan the payment prescribed. If the Plan should be the terminating party, such termination shall also be without prejudice to prior claims and shall not alter its liability for any unpaid services which have been rendered by the participating physician prior to the date the termination becomes effective.

IN WITNESS WHEREOF, the Plan has caused these presents to be signed by its duly authorized officers and its corporate seal to be affixed, and the participating physician has hereto set his hand and seal the day and year first above written.

----- (L.S.)

(Participating Physician)

(Street Address)

(City)

(SEAL)

SOUTH CAROLINA MEDICAL CARE PLAN

By -----

SUBSCRIBER'S CERTIFICATE SURGICAL CONTRACT

THIS CONTRACT made and entered into between the Subscriber named in the application and the South Carolina Medical Care Plan, a non-profit corporation,

ENTITLES the Subscriber, in consideration of the application and payment in advance of the subscription charge provided herein, to have the South Carolina Medical Care Plan pay for professional services, as herein defined, rendered to the Subscriber and, if listed on the application, the Subscriber's spouse, and

unmarried dependent children until they attain nineteen years of age, for a period of one month next following the effective date of this contract, upon the terms and subject to the conditions set forth herein.

IN WITNESS WHEREOF the South Carolina Medical Care Plan has caused this Contract to be executed by its duly authorized officers, and its Corporate Seal to be hereunto affixed.

SOUTH CAROLINA MEDICAL CARE PLAN

J. Decherd Cuccs, M. D., President,

George D. Johnson, M. D., Secretary

Allen D. Howland

Executive Director

TERMS AND CONDITIONS

1. Definitions and Benefits:

- A. The term "professional services," as used herein means surgical and obstetrical (maternity) services as herein defined and rendered by a Doctor of Medicine selected by the patient from among the participating physicians of the South Carolina Medical Care Plan.
- B. Surgical services shall include operative and cutting procedures for the treatment of diseases, injuries, fractures, and dislocations, rendered by a physician to a patient in a regularly accredited hospital, or in the doctor's office, or clinic.
- C. Obstetrical (maternity) services shall include only delivery and early post-partum care rendered in a regularly accredited hospital or the doctor's office or clinic, or in the home, to the wife of a regularly enrolled member under the family agreement or to a wife who may be herself enrolled as the member of the Plan, likewise under the family agreement.
- D. Obstetrical (maternity) services shall not be available until this agreement has been in force for ten consecutive months, and surgical services for tonsillectomies, hemorrhoidectomies and herniorrhaphies (except operations on strangulated hernia), shall not be available under the terms hereof until this agreement has been in force for six consecutive months. All other services provided for under the terms hereof shall be available from the effective date of this agreement.
- E. Determination by the South Carolina Medical Care Plan as to whether services rendered are within the terms of this contract shall be conclusive; and likewise, when such services are covered by the provisions hereof, any question as to whether the same are to be classified as surgical or obstetrical shall be determined by the Plan.
- F. A participating physician is a Doctor of Medicine duly licensed under the provisions of Article 7, Chapter 121, of the Code of Laws of South Carolina, 1942, as amended, who has contracted with the South Carolina Medical

THE HIGH-PROTEIN INFANT FOOD



The incidence of mild protein deficiencies in children, predisposing toward infections and edema, is reported^{1,2} much greater than generally realized. Infant and adolescent requirements—not only for tissue repair and maintenance, but also for growth—are much higher than in adulthood.³ To insure adequate protein intake in infancy, DRYCO—Borden's high-protein infant food—is ideally suited as a basis for formula building. It furnishes *all the essential amino acids*. Its low fat content minimizes gastro-intestinal upsets due to fat intolerance, while its intermediate carbohydrate content lends itself for prescription with or without added carbohydrate. Quickly soluble in cold or warm water, DRYCO contains adequate vitamins A, B₁, B₂ and D, plus essential milk minerals.

- References: 1. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:442, 1936.
2. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:452, 1936.
3. Sahyun, M.: *Am. J. Dig. Dis.*, 13:59, 1946.

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DRYCO is made from spray-dried, pasteurized, superior quality whole milk and skim milk. Provides 2500 U.S.P. units vitamin A and 400 U.S.P. units vitamin D per reconstituted quart. Supplies 31½ calories per tablespoon. Available at all drug stores in 1 and 2½ lb. cans.



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Care Plan to render services to subscribers to said Plan and their covered dependents under the family agreement, in accordance with the fee schedule, By-laws, rules and regulations of the Plan.

2. General Limitations:

The benefits as set forth above shall NOT include the following:

- A. Professional services for the treatment of any condition not requiring surgical or obstetrical service as herein defined.
- B. Professional services rendered in the home, except in obstetrical cases as herein provided, or in any place other than a regularly accredited hospital or the office or clinic of a duly licensed Doctor of Medicine.
- C. Pre-natal care and services during pregnancy other than necessary surgery.
- D. Hospital, anesthesia, and laboratory services.
- E. X-Ray service, except diagnostic in cases of injury or accident.
- F. Plastic operations for cosmetic or beautifying purposes.
- G. Professional services which are provided and paid for under Workmen's Compensation Laws or which can be obtained without cost to the subscriber by compliance with the laws or regulations of any federal, state, municipal, or other governmental body.

3. Income Limit Entitling Subscriber to Payment in Full:

Doctors of Medicine participating with the South Carolina Medical Care Plan and rendering to the subscriber and/or his covered dependents such services as herein provided, shall make no additional charge therefor unless the annual income of the subscriber under whose contract such services are rendered, combined with the annual income of the members of his family entitled to qualify as covered dependents, exceeds Thirty-five Hundred (\$3,500.00) Dollars. In the event that the total annual income of the subscriber and the members of his family entitled to qualify as his covered dependents exceeds Thirty-five Hundred (\$3,500.00) Dollars, the Plan agrees to pay its standard fee to the participating physician who renders the service. If there is any balance due such physician it shall be the personal responsibility of the subscriber to pay such balance, and the South Carolina Medical Care Plan shall not be responsible therefor.

4. Determination of Income:

The income classification of a subscriber shall be determined in the first instance by agreement between the subscriber and the Plan on the basis of representations made by the subscriber in his application. Any question arising between a physician and the subscriber with respect to the income

classification of the latter shall be submitted to and determined by the South Carolina Medical Care Plan.

5. If the services covered by this agreement are rendered in an emergency by a duly licensed Doctor of Medicine not participating with the South Carolina Medical Care Plan, the Plan will pay for such services at the same rate as that paid to participating physicians.

6. Subscription Rates:

- a. The subscriber, who is the holder of the type contract, specified in his application card, has paid to the South Carolina Medical Care Plan the amount specified below for such type contract, as the subscription charge for one month, in advance:

Subscriber	\$.85
Family (Subscriber, spouse, and unmarried children up to 19 years of age)	\$2.25

- b. This contract may be renewed, and when so renewed, shall continue in effect, from month to month, by the payment to and acceptance by the Plan of the subscription charge then in effect. Such subscription charge shall be payable in advance, monthly or quarterly.

The South Carolina Medical Care Plan reserves the right to change the rates on thirty (30) days' written notice to the subscribers, which notice shall be given only after approval of such change by the Insurance Commissioner of the State of South Carolina.

- c. Failure to pay the subscription charge in advance as provided herein shall automatically terminate this agreement and all benefits provided hereunder.
7. Reports on the diagnosis and treatment of conditions for which subscribers and their dependents are entitled to service under this agreement shall remain confidential, and it is agreed that the request for professional services is authorization to the Doctors of Medicine to make such reports.
8. The subscriber's Identification Card shall be presented to the Doctor of Medicine when service is requested.
9. This subscription agreement and the benefits hereunder are personal to the subscriber and are not assignable by the subscriber.
10. No action or suit at law or in equity shall be commenced until thirty (30) days after written notice of claim has been given by the subscriber to the South Carolina Medical Care Plan, nor shall such action be brought at all later than two years after acceptance of service.
11. The application submitted by the subscriber and this agreement shall constitute the entire contract between the parties. No agent or employee is authorized to vary, add to, or change this agreement as set forth, in any manner or degree.

ABSTRACTS

de Takats, G., Julian, O. C., Fowler, E. F.: The Surgical Treatment of Essential Hypertension. IV. Case Selection and Technique as Influencing Results, Surg. 24: 469 Sept. 1948.

The authors classify essential hypertension into 3 groups as a means of evaluating pre-operative cases and to express the degree of organic damage:

Group 1. Age below 40 years; minimal or no detectable organic damage; normal blood pressure on complete rest or barbiturates; casual diastolic pressures above 100 mm. Hg.

Group 2. Age from 20 to 55 years; moderate vascular sclerosis in all organs; well-demonstrable angiospasm; diastolic pressures cannot be lowered below 110 mm. Hg. by any method; rising diastolic pressure during the course of last 6 months.

Group 3. Large recurrent retinal hemorrhages and exudates or papilledema; high fixed diastolic pressure which cannot be lowered below 120 mm. Hg.; congestive or anginal heart failure; poor renal function; numerous cerebrovascular accidents; an actual malignant or pre-malignant state of hypertension.

The various types of sympathectomies are discussed. The authors' minimal procedure in 250 cases consisted of total splanchnectomy with removal of the sympathetic chain above the 9th dorsal and below the second lumbar segment. There were two operative deaths, both attributed to anesthesia, and no post-operative mortality. All patients have been followed for at least 1 year and not more than 6 years. In patients subjected to operation who were classified in group 1, there was 85% success; in group 2, 75% success; in group 3, 0% success. Patients in group 3 were not considered suitable candidates after 1942 when it was demonstrated that they did not benefit from the procedure.

The causes for failures in order of frequency were poorly selected cases, insufficient denervation, unexplained, heart failure and stroke. The possible role of cortico-adrenal factor in the maintenance of essential hypertension was stressed in cases when it was found that splanchnic section was unsuccessful.

Graham, Evarts A.: Bronchiogenic Carcinoma, Surg., Gynec. and Obst. 88: 129 January 1949.

Carcinoma of the lung is believed to have replaced carcinoma of the stomach as the most common visceral cancer. Because of its frequency it is important that great emphasis be placed on the desirability of early diagnosis and on the now well established fact that it is no longer a hopeless or incurable condition, if the proper treatment is instituted at an early stage.

It is primarily a disease of males during or after middle age. Since its origin is usually in a bronchus, the most common symptom is cough, which in 50% of cases is productive of sputum containing streaks of blood. However, when it arises in a small bronchus, both cough and bloody sputum may be absent and when this is true, the patient usually presents no symptoms until the condition is too far advanced to be curable. As in other forms of cancer, pain and loss of weight are late symptoms and often denote incurability.

With a combination of X-ray, bronchoscopy and examination of bronchial secretion for cancer cells, the definite diagnosis can be made in about 85% of cases. In the remaining 15%, it is necessary to perform an exploratory operation. When carcinoma is suspected, it is dangerous to subject the patient to a period of observation, waiting for diagnosis to be established. Many curable cases are converted into incurable ones by such a procedure.

The operative mortality rate has dropped from 53% to 5% in the past 15 years. The 5 year survival rate since 1942 is 28%.

The principal problem in improving the results is to have patients come for help early enough to permit operation. This means recognition of the frequency of this carcinoma, the necessity of proper early examination, and the fact that the early case is curable.

Robinson, D. W.: Blood Loss from Donor Sites in Skin Grafting Procedures, Surg. 25, 105, January 1949

Because of the danger of shock associated with major skin grafting procedures, a study was carried out to determine the quantity of blood lost from donor sites during operation. The method of calculating the amount of blood lost was weighing blood soaked sponges and comparing this with dry sponges.

The dermatome was used for cutting skin grafts in 35 patients whose age, sex, state of nutrition, and pre-operative hemoglobin varied.

The average loss of blood was 46 c.c. per drum of skin. When the depth of the graft was under .019 inches, the bleeding varied between 39 c.c. and 44 c.c. The donor site location varied considerably in amount of blood lost, in that the back and buttocks averaged 51 c.c. per drum, the abdomen and chest 41 c.c. and the thighs 38 c.c.

Patients in a good state of nutrition lost more blood than those considered in poor condition. The average loss per drum in patients whose hemoglobin was 80 percent or more was 61 c. c. while for those patients

below 80 percent, the average loss was 34 c.c. The blood loss in children under 10 years of age was almost twice that of adults.

Although cyclopropane has been said to cause increased bleeding at operation, the average blood loss per drum when it was used was 36 c.c. compared to

49 c.c. for ether.

With these figures available, one may calculate the amount of blood lost during skin grafting and be prepared to replace blood necessary for the patient's well-being.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. J. L. Sanders, Greenville, S. C.

Publicity Secretary: Mrs. Kirby D. Shealy, Columbia, S. C.

MEDICAL AUXILIARY HAS PROGRAM GIVEN BY OFFICIAL OF STATE CHAPTER

Mrs. David Adcock of Columbia was guest speaker at the Dutch luncheon given September 6 in the private dining room of the Andrew Jackson Hotel by members of the York County Medical Auxiliary.

Mrs. Adcock, state director of publications for the auxiliary, conducted a school for auxiliary officers and chairmen. Mrs. Alton G. Brown presented the speaker.

Mrs. Gaston Quantz, new president of the auxiliary, presided. She gave the goals for the year which include a gain in membership, aiding in the fight against socialized medicine and help with the nurse recruitment program.

Auxiliary members made plans to hold a picnic next month for the 16 new members of the York County Hospital School of Nursing. Mrs. Frank Gaston is head of the committee planning this outing.

Mrs. Quantz thanked members for aid with the Red Cross Bloodmobile. Mrs. W. W. Fennell, secretary, read a letter from Mrs. J. L. Sanders of Greenville, president of the state auxiliary, asking for help with the pre-natal and maternal welfare program. The York county group offered their services to the county nurse.

The table was centered with an exquisite arrangement of fall flowers.

EXECUTIVE BOARD MEETING

The mid-year executive board meeting of the Woman's Auxiliary to the South Carolina Medical Association was held on October 5 in the Hotel Otteray at Greenville. A full account will be given in the next issue.

WOMAN'S AUXILIARY TO THE SOUTHERN MEDICAL ASSOCIATION

The Woman's Auxiliary to the Southern Medical Association will be held in the Hotel Sinton at Cincinnati, November 14-17. The hostess organization for this meeting is the Kentucky Auxiliary.

OUR PRESIDENT WRITES

The following article was written by our president, Mrs. J. L. Sanders, upon request, for publication in another periodical of the state. It was with pleasure that we received permission to use it here.

"There is the necessity of all women being on the alert to the aspirations of those who would enforce a government-controlled plan of medical and hospital care. It is urgent that we act wisely to preserve and to protect our families and homes by preventing the Government from taking possession of our lives by

expressing opposition to the present proposed health bill. It is also essential that we are awakened to the serious needs of improved and concrete health programs in rural communities. The importance of this service can't be overestimated.

"We, as an auxiliary, are placing special emphasis on nurse recruitment. It is our ambition to acquaint those who are interested in this noble work, with the many opportunities and advantages, both from an educational, social, and professional standpoint, that are offered during training.

"We aspire to placing in every office, home, college, hospital, and public school the Hygeia magazine which is the official organ of the American Medical Association. It contains valuable information which everyone should read and appreciate. Information breeds interest, so be informed—be interested."

ECHOES FROM OUR CONVENTION LAST MAY

Mrs. Clay Evatt, Charleston, S. C.

"One of the greatest needs in S. C. is more women in the field of nursing. No group of organized women is better qualified to promote the recruitment of nurses than the Auxiliary to the S. C. Medical Association. We urge all members to cooperate in encouraging girls to study nursing. Since the days of Florence Nightengale, nursing has been one of the noblest professions for women.

Mrs. M. Nachman, Greenville, S. C.

"It is with a deep feeling of pride in our organization that we passed a resolution opposing any form of compulsory health insurance. We all feel a responsibility for health education which we hope to bring to the general public in greater abundance as time unfolds."

Mrs. H. L. Timmons, Columbia, S. C.

"The Woman's Auxiliary to the S. C. Medical Association stands with the doctors who comprise the S. C. Medical Association in opposing compulsory health Insurance or Socialized medicine. We believe such a measure would lower the standards of the profession and give poor service in the field of health."

Mrs. W. H. Poston, Pamplico, S. C.

"I was impressed with the forward looking program of the Woman's Auxiliary to the S. C. Medical Association, and the great work being done by this organization."

PUBLIC HEALTH NEWS

CHANGES IN PERSONNEL

The Executive Committee of the State Board of Health, at a meeting held on the 31st day of August, has instituted certain changes in the assignment of personnel, effective September 1, 1949. We list them as follows:

Dr. G. S. T. Peeples has been elected Director of Local Health Services.

Dr. Frank Geiger, former Director of Tuberculosis Division, has been elected Director of the Division for the Control of Heart Disease. In addition to the Heart Disease Program, he will also be Director of Cancer Control Program.

Dr. Hilla Sheriff, Director of Maternal and Child Health, will assume the directorship of the Crippled Children Program.

Dr. Weston Cook, orthopedic surgeon, will be surgeon in charge of the Division of Cerebral Palsy and Speech Therapy, on a part time basis.

Mrs. Hettie Rickett's title has been changed to State Supervising Nurse, under the direction of the State Health Officer, and Director of Nurses in Local Health Services under the direction of Dr. Peeples.

Mr. Charles Farish has been appointed as Director of Sanitation in Local Health Services under the direction of Dr. Peeples.

Mr. H. M. Fairley's title has been changed to Director of the Hospital Division.

Miss May Reed, formerly the orthopedic nurse in the Greenville District, has been transferred to Public Health Nurse in District V.

Mrs. Harriet Chapman, who was formerly the district nurse for the Pee Dee area, has been assigned to mental health activities, and as local supervising nurse for the Counties of Lee, Darlington and Ker-

shaw.

The Executive Committee approved the division of the State into six districts, with the following assignment of personnel:

District I—Oconee, Pickens, Anderson, Greenville, Spartanburg, Cherokee and Union Counties

Sanitarian—Mr. F. A. McCown, Nurse—Mrs. Evelyn Martin.

District II—Abbeville, McCormick, Greenwood, Laurens, Newberry, Edgefield and Saluda Counties.

Sanitarian—Mr. J. D. Kirby, Nurse—Mrs. Minnie H. Blease.

District III—Aiken, Lexington, Barnwell, Bamberg, Calhoun, Orangeburg and Clarendon Counties.

Sanitarian—Mr. J. T. Hane, Nurse—Mrs. Dell Rogers Harper.

District IV—Allendale, Hampton, Jasper, Beaufort, Colleton, Charleston, Dorchester and Berkeley Counties.

Sanitarian—Mr. H. D. McDaniel, Nurse—Mrs. Amelia Tanksley.

District V—York, Chester, Fairfield, Richland, Sumter, Lancaster, Kershaw and Chesterfield Counties.

Sanitarian—Mr. E. M. Causey, Nurse—Miss May Reed.

District VI—Lee, Darlington, Marlboro, Dillon, Florence, Marion, Horry, Williamsburg and Georgetown Counties.

Sanitarian—Mr. W. W. Vincent, Nurse—Mrs. Blanche R. Speed.

Under authority of an Act of Legislature, the Executive Committee has designated Dr. G. S. T. Peeples as Assistant State Health Officer.

Ben F. Wyman, M.D.

State Health Officer and

Secretary, State Board of Health

NEWS ITEMS

Dr. W. McNeill Carpenter of Greenville was elected president of the South Carolina Society of Ophthalmology and Otolaryngology at the recent annual meeting of the organization. Dr. Joe Workman of Columbia is Vice-President, and Dr. Roderick Macdonald of Rock Hill, Secretary.

Dr. Charlton P. Armstrong is now associated with Dr. Mordecai Nachman of Greenville in the practice of Urology.

The South Carolina Pediatric Society held its fall meeting in Columbia on Sept. 12. Guest speakers for the occasion were Dr. John A. Toomey, Professor of Clinical Pediatrics, Western Reserve University, and Dr. Irving McQuarrie, Professor of Pediatrics, University of Minnesota School of Medicine.

An outstanding Neuropsychiatric Seminar was held in Edgewood Sanitarium, Orangeburg, Sept. 15-17. Nationally known speakers from several states were on the program. The attendance was excellent.

The Piedmont Post-Graduate Assembly was held in Anderson on Sept. 20 and 21. Out-of-state speakers included Drs. E. A. Hines, Mayo Clinic, John R. McCain, Atlanta, Calvin B. Stewart, Atlanta, Paul B. Beeson, Atlanta, Peter B. Wright, Augusta. Dr. Roderick Macdonald, President of the S. C. Medical Association, also spoke.

Dr. Bartlette M. Cheatham is now associated with Dr. J. E. Crosland of Greenville, in the practice of general medicine.

The International College of Surgeons, United States Chapter, will hold its fourteenth Annual Assembly and Convocation in Atlantic City, New Jersey, November 7, 8, 9, 10, 11, 12, 1949, according to David B. Allman, M. D., Atlantic City, Chairman of the Assembly.

The program will include scientific sessions on subjects in the fields of general surgery; eye, ear, nose and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic and neurological surgery, as well as special surgical clinics held in

Philadelphia hospitals on November 7. In addition, an extensive technical and scientific exhibit will be presented by leading manufacturers of surgical instruments, x-ray apparatus, operating room and hospital equipment, pharmaceuticals and others, Dr. Allman said. Special entertainment for the doctors' ladies has been planned.

Arnold S. Jackson, M. D., Secretary of the United States Chapter, has reported from Madison, Wisconsin, that over 500 surgeons will be received as Associates and Fellows of the International College at the Convention to be held in Convention Hall, Atlantic City, on November 10.

All doctors of medicine interested in surgery and its advancement are invited to attend, and can obtain a program upon request to Arnold S. Jackson, M. D., Secretary, Jackson Clinic, Madison 4, Wisconsin. For hotel reservations, contact E. D. Parrish, Haddon Hall, Atlantic City, New Jersey.

CORRESPONDENCE

AMERICAN UROLOGICAL ASSOCIATION

The Editor,
Journal of
So. Carolina Medical Assn.
Florence, South Carolina.

Dear Doctor:

Please publish in the forthcoming issue of your journal the following notice:

"Urology Award"—The American Urological Association offers an annual award of \$1000.00 (first prize of \$500.00, second prize \$300.00 and third prize \$200.00) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Washington, D. C., May 29-June 1, 1950.

For full particulars write the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, N. J. Essays must be in his hands before February 20, 1950."

DEATHS

WALTER L. BATES

Dr. Walter L. Bates passed away after a brief illness on August 11, 1949.

A native of Spartanburg County, Dr. Bates received his formal education at Furman University and Vanderbilt University School of Medicine (Class of 1919). In 1920 he went to Greenville and engaged in general practice up to the time of his death. He was family physician to most of the employes of the Southern Railroad in Greenville and these people, who knew him so well, adored him.

Dr. Bates was never married. He is survived by his brother, Dr. Charles O. Bates.

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of the

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Obstetrical Lessons From Studies Of Maternal Mortality

J. DECHARD GUESS, M. D.^o
Greenville, S. C.

The Committee on Maternal Welfare of the South Carolina Medical Association has completed studies of 100 maternal deaths which occurred in the state in 1948. There remain about 50 deaths yet to be studied. The number of deaths which occurred in 1948 is essentially the same as that of the preceding year.

The primary purpose of the study of these deaths is to find the answers to three questions, namely, why did these women die, what could have been done to save them, and what can be done to prevent similar deaths in the future.

These studies have revealed a number of interesting things which will be discussed in this and subsequent communications to be published as the work proceeds.

The doctors of the state have been generally co-operative. Several have consistently declined to help. Others have been hurried and careless in submitting information, and the information given at times has been incomplete, contradictory, or inaccurate. There has been considerable excuse for this in that the committee began its studies late in the year, and there is no doubt that in many cases the reporting doctor had forgotten details of the case. It is hoped that, as the committee catches up with the cases, questionnaires will go out much sooner after termination of each case with consequently more accurate reports from the doctors. However, at best there will be a considerable time lag between the time of death and that when a copy of the death certificate reaches the committee. Therefore, the committee wishes to suggest that, in the case of maternal deaths, the attending physician make some notes at the time of the death so that he can give a full and accurate account of the circumstances of the death when he receives a questionnaire. Where information has been incomplete, the committee has resorted to other sources of information. Many cases were midwife cases before the doctor was

called in by her, often shortly before death of the patient. The committee has found that in these instances, the midwife often can give valuable information. Sometimes a member of the deceased's family has been asked about the circumstances of the death. At times the death certificate is signed by a physician who referred the patient to another physician shortly before death, and at times the reverse is the case. When either of these has occurred, the committee has sought complementary information from each physician.

The proper completion of death certificates often is a difficult task which requires some thought. The criteria for evaluating the adequacy of the cause of death certification as stated in the Vital Statistics Instruction Manual issued by the National Office of Vital Statistics are as follows:

"In a properly filled out death certificate, the causes of death should be given in detail and listed in causal sequence. Wherever possible, terminal conditions and complications should be accompanied by a statement of their underlying causes. A satisfactory cause-of-death certification should answer the questions, 'when,' 'where' and 'how.' 'When' for the duration of the disease or condition. 'Where' for the anatomical site affected, and 'how' for etiology or cause of the disease or condition." Further, in reporting deaths of mothers, deaths before delivery and deaths after delivery should be clearly differentiated. It happens frequently that terminal conditions like cerebral hemorrhage, edema of the lungs and acute cardiac dilatation are listed as the primary causes of death, with eclampsia or nephritis with hypertension listed as secondary.

The committee in its own records has removed from its list of maternal deaths, 5 cases which had been coded in the Office of Vital Statistics as maternal deaths. Ten other cases were not removed, because coding regulations required their inclusion. However, pregnancy and labor were incidental or aggravating conditions. In several instances, the doctor who filed

^o(From the Committee on Maternal Welfare, S. C. Medical Ass'n. Read before the Annual Convention, May, 1949)

the death certificate was inaccurate in his statements and showed a causal relationship between pregnancy or labor and the cause of death when none existed.

Florence, Orangeburg and Sumter counties are high mortality centers. Florence had 9 deaths and Orangeburg and Sumter had 7 each. No attempt to account for these facts will be made now. Twelve counties had no maternal deaths and half of these counties have no hospitals, and so presumably send cases requiring hospitalization into other counties. The relationship of county of death to that of usual residence has not been studied.

Of the 100 deaths studied, 26 were caused from eclampsia. Six of the group were white and 20 were colored. There were 6 cases of chronic nephritis, with hypertension and terminal catastrophies like cerebral hemorrhage, coronary occlusions and uremia. These will be included in the report of the Bureau of Vital Statistics as maternal deaths from toxemia. We will be charged with 32 deaths from toxemia of pregnancy or the puerperium.

There were 2 cases of fulminating, rapidly fatal eclampsia. These cases had had careful and regular prenatal care and gave no indication of toxemia until a few hours before they died. These cases have to be accepted as unavoidable and their deaths rated as inevitable. The remaining have to be classified as unnecessary deaths in the sense that they either presented unmistakable evidences of progressive toxemia days before convulsions occurred, or else they had received no prenatal care in late pregnancy. Several had had medical observation in contradistinction to medical treatment.

Dr. Louis H. Douglass, in his recent address before the South Carolina Obstetrical and Gynecological Society stated categorically that preeclampsia is a curable disease, while frequently eclampsia is not. He stressed a well-recognized fact that prevention of eclampsia, by treating preeclampsia, is the only generally successful form of management.

However, many of our doctors and our public health nurses do not seem to recognize the truth of that statement. Some of the women who died attended public health clinics, showed the signs of beginning toxemia and were sent home with very indefinite instructions and with no realization of their danger. Others were referred to private physicians who did equally as badly. Two patients were hospitalized because of severe preeclampsia, successfully treated, and then were allowed to go home undelivered, only to return within a few days, in convulsions, and with death inevitable.

It is not wise, probably, to send home intelligent, well-disciplined patients whose preeclampsia has improved under hospital care before they are delivered. It is almost a wasteful squandering of such care as they have already had, to allow the usual service case to leave the hospital undelivered.

The following are some things which would immediately lower our mortality from eclampsia:

1. Better follow-up by the staff of the Public Health prenatal clinics. The tendency seems to be for patients to come to the clinics more or less regularly, at least until they have a record of the four visits required before they can employ a midwife. Then in the last trimester, when they do not feel so comfortable, and when their danger is greatest, they stay at home. The nursing staff of most of the county health departments is not large enough to do adequately follow-up of these cases.

2. Recognition by the doctors that preeclampsia, except in its earliest and mildest stages, is a serious disease, poorly and inadequately treated at home, at best, and hopelessly so treated where the patient is poor, undisciplined, and ignorant. These cases should be promptly hospitalized, vigorously treated, and then delivered, before they are allowed to go home.

3. Midwives who recognize difficulties in labor should have authority to hospitalize patients promptly, if there is delay in securing a doctor to see the case.

4. There should be no red tape to delay the admission to hospitals of severely toxic women. The public agency which has regulation of admission of charity cases to hospitals, should be made to realize that these are truly emergencies.

Twenty-eight cases of our series died from hemorrhage. Seven of these were white and 21 were colored. The distribution in the latter group is interesting. There were 7 deaths from postpartum hemorrhage, 6 deaths from placenta previa, 5 from ruptured ectopic pregnancy, 1 from abruption of the placenta, and 2 from hemorrhage of abortion. One death from postoperative hemorrhage after therapeutic abortion has to be ascribed to cancer of the breast. At least 4 of these women died within 20 miles of a hospital—2 because the roads were impassable, and 2 because the doctor seems to have failed to realize that he was watching a woman bleed to death and doing nothing about it. Most of the deaths from hemorrhage occur in hospitalized cases—cases sent in moribund. The incidence of death from hemorrhage associated with pregnancy is greatly increased, or so I believe, by the marked anemia which is allowed to develop before bleeding starts. It takes comparatively little blood loss to result in the death of a woman whose hemoglobin was 35 to 45 per cent before bleeding began.

So far as this study showed, no woman died from hemorrhage because there was no hospital to go to. Most of them got to hospitals. But so often the hospitals were not equipped to treat them—no blood bank, no quickly available donors, no technician on duty or available—so that treatment had to be infusion of plasma and glucose solution. Further, doctors seem to be inclined to temporize about actively treating postpartum or postabortal hemorrhage by evacuation of the uterus. Ergotrate or pituitin or both, fundal

massage, repeated, repeated again after consultation, blood transfusion ordered, death of the patient before the order is executed was the sequence of events in one sad case, when the evidence suggests retained secundines as the cause of the bleeding. The interior of the uterus was never explored. In another somewhat similar case, hysterectomy was done after the patient was already in profound shock, from which she never recovered.

One danger of the small community hospitals which are in operation or planned is that they will give a sense of false security—false because of lack of equipment and personnel, and because of the lack of training of the staff in emergency measures and its tendency to overlook the simple things in order to do the more dramatic.

The incidence of puerperal sepsis is unbelievably low, being 7 cases in the 100 studied. Three of these followed caesarean section, and none of the sections appear to have been justified by the reports of the cases. Only 1 case was from criminal abortion.

There was only 1 anesthetic death in the series. This was caused by spinal anesthesia. There were 2 deaths from obstetrical shock or exhaustion, and 5 cases died of pulmonary embolism. One of these followed abortion, and 1 followed hysterotomy for therapeutic abortion.

It is with regret that I have to report that caesarean section, under general anesthesia, is still done in our state to cure eclampsia; that caesarean section is still used as a method of delivery where tubal sterilization

is planned; that instructions to be careful and to avoid future pregnancies continue to be given to ignorant women, with chronic nephritis, rather than insisting that they have tubal ligation as a life-saving measure; that proteins are still feared in albuminuria and elevation of blood pressure in pregnancy; that calcium is still administered in capsules or wafers instead of in milk; that rapid weight gain is not universally associated in the minds of our doctors with probable occult or dependent edema; that the uterus is still believed to be a safer place for a baby before term than an incubator, even though the mother be suffering from serious nephritic toxemia; that forceps to the floating head are sometimes applied, and that manual dilatation and extraction, the old accouchement force, is still used at times to treat eclampsia.

One of our colleagues was recently told by a general surgeon, that obstetrics had made no progress in the last one hundred years. As it is practiced by many general surgeons, the statement approximates truth. Obstetrics is the only branch of medicine which can be practiced legally by one not licensed to practice medicine. Other and perhaps more alluring courses are crowding out obstetrics in the curriculum of our medical schools to an ever increasing degree. Internes tend to find only the dramatic in labor and delivery interesting. Perhaps, those of us who are giving our lives to obstetrics as a specialty, who are giving of our energy and our time to instruct our colleagues, and who lose sleep over the deaths of 150 mothers, most of whom should be alive today—I say that those of us who do these things are perhaps screwballs—and if not so, then we are at best male midwives.

Convulsions In Childhood

JOHN A. TOOMEY, M. D.
Cleveland, Ohio

The commonest cause of convulsions in children is a high fever associated with an infectious disease. If there are a half million epileptic persons with convulsions each year, then comparatively, millions of patients with infectious fevers have convulsions. Observation for a quarter of a century has taught me to be optimistic about their outcome, with reservations as I will indicate.

Convulsions may occur at any time during the course of an infectious disease, but usually they take place at the onset when the temperature is highest and when a rash, if present, is most prominent. They occur at any age but are commonest from birth to 2 years of age.

Convulsions may be localized and unilateral or generalized with no localization, or a combination of reactions may be present. Objectively, convulsions are similar, no matter what the cause. In the majority of patients but one attack occurs, the reaction being so severe that medical aid is immediately sought and procedures adopted to prevent other attacks. With the use of antibiotic substances and sulfonamide drugs, the incidence of this condition has sharply decreased.

Why convulsions occur, no one knows. To say that they are caused by toxins, that the cortex is less stable, that the chemical balance has changed, that there is an aberrant discharge of nerve impulses to the muscles, causing muscular contractions, is begging the question. I have never tried consciously to produce convulsions clinically, but I have done it accidentally, when 2 patients with encephalitis were given too much fluid intravenously. The convulsions which occur with fever do not ordinarily cause death. If the patient dies, it usually is from the disease or from one of its complications.

It has been stated that from 15 to 20 per cent of those persons who have convulsive attacks with fever have recurrences later. Although this has not been our general experience it has happened often enough to draw attention to the fact that they can occur. Such an incidence is not my experience. Attacks recurred in 2 to 3 per cent, and damage to the brain with mental involvement was observed in less than a fraction of 1 per cent of my patients.

Certain infections are more apt to be accompanied with convulsive seizures than others. If the condition called terminal convulsion which appears just before death from any disease—the convulsive, tetaniform, stretching muscular movements which accompany the act of dying—is ignored, the commonest conditions causing convulsions are infections of the upper and

lower parts of the respiratory tract due to any bacterium (*Pneumococcus*, *Hemophilus influenzae* and others) and, especially, infections of the middle ear of infants.

With whooping cough, the convulsions may be general. Usually, not more than four or five episodes occur, and rarely do the attacks become repetitive to the point that the patient goes into an epileptiform fit. I have seen 29 such persons among the thousands admitted to the hospital in the past twenty-five years. Convulsions in the disease are followed occasionally by hemiplegia, from which, with persistent physical therapy, recovery is possible within a few months. Occasionally, however, the patient does not completely recover and is left with a residuum of clawlike fingers and homolateral paralysis of the facial nerve, or becomes, as did 1 patient, a spinal animal.

Uremia associated with scarlet fever is ushered in by an elevated temperature; often convulsions occur within a few weeks after the initial symptoms appear. These convulsions may persist for a short time, but they respond well to ordinary therapy, and never in my experience has any residuum resulted.

Patients with measles may go into a somnolent state following the convulsions, which may last as long as a month. After an acute infection, such as chickenpox, measles, influenza and the like, such a condition may supervene; that is, the patient may become lethargic after the convulsion. The patient usually comes out of the coma within at least two weeks. He may recover even after a continued period of four weeks of lethargy with no mental retardation. However, if such a state persists longer than twenty-one days, there is cause for worry, as permanent mental damage may result, especially when the patient has a normal temperature and a continued large amount of protein in the spinal fluid.

The ordinary type of encephalitis is not commonly associated with convulsions. Occasionally, convulsions occur with pyelitis, poliomyelitis or mumps. I have never seen permanent mental changes in a patient with parotitis, although convulsions in this disease are not at all uncommon.

The convulsive states that are most serious are those that occur with measles, whooping cough and vaccination. Measles encephalitis is a distressing complication and even, as we said before, if the patient does come out of his lethargy after twenty-one days and within two weeks there may be cause to worry regarding permanent mental changes. The same is true of whooping cough which is associated with severe mental changes if such occurs and whooping cough vaccine may cause encephalitis. But the physician is warned by the reactions after the first dose and

can act accordingly. Encephalitis following after vaccinations does not occur frequently. We have had the eighty-second proven case in the United States due to vaccination which is not too numerous under the circumstances. We would like to try convalescent animal serum which we have prepared in these cases, but we have never had one which was seen at the right time.

The patient with rabies has convulsions, but these are part and parcel of the disease. The same observation may be made of tetanus, but in this disease the convulsions can be controlled, and if they are controlled the patient usually recovers. It is much more important to control the convulsions than to give specific antitoxin.

Any acute infection may be accompanied with convulsions. The most important thing is not that the person has convulsions but the discovery of their cause and their subsequent control. If somnolence supervenes, it should be terminated. I cannot subscribe to the theory that convulsions tend to create a trigger-like sensitivity of the cortex, so that it is ready to respond more easily in the future to some other infection. Doubtless, such instances occur in patients who come to a specialized clinic, and their numbers impress the physicians in the

clinics. However, when the large number of persons with infectious diseases is considered, the incidence of convulsions becomes small indeed.

The treatment of the condition is first of all directed against the most common of all convulsion causes, the fever, so that limited uses of sulfadiazine, penicillin, aureomycin are indicated. Very frequently the fever will go down and the convulsions disappear. Of course if there is a bulging ear this should be revealed promptly. In convulsions from whooping cough, measles, encephalitis or from any other unknown reason efforts should be made to render the patient quiet and this is done by the use of such sedatives as phenobarbital, and if the convulsions continue some sodium pentothal and this is given to the point where the patient is absolutely lax. One doesn't like convulsions because they may last a long while. The patient may have anoxia which will be extremely difficult to counteract if it persists for a long time. The prognosis, however, in general is fairly good.

We are not dealing with the convulsions associated with the epileptic form or types where a diet may be indicated. In fact a high fat diet should be tried as advocated by such authors as our guest speaker Dr. McQuarrie and Dr. Peterman from Milwaukee.

Special School Therapy For The Problem Adolescent

LESLIE R. ANGUS, M. D., Director
Psychiatric Services, Devereux Schools,
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Special schools began operation in America one hundred and one years ago, when within a few months of each other, a public and a private institution for the resident training of mentally handicapped children were opened in the State of Massachusetts. Both of these organizations, and the numerous others which rapidly followed their example, emphasized the educational character of their work by insisting on their right to the title of "school" rather than hospital, their claim to a place in the educational system, and their belief that by the persistent application of ordinary pedagogical principles, or by the elaboration of new techniques based on these foundations, many of the "mentally deficient" might be restored to a place in the regular academic system or to society. A few years later, when it became evident that the glowing expectations first held forth by these pioneers were not being realized on any extensive scale, concern about the large number of cases, coupled with the de-

pressing statistics supplied by research workers on the influence of heredity, brought about a distinct change in attitude. The public and also those in charge of institutions, began to worry about the possible influence of the feeble-minded on the community and the possibility that they like the meek literally might inherit the earth by sheer force of numbers. Thus the program shifted from emphasis on treatment (by education largely) to segregation; sterilization measures were proposed, and sporadically adopted, and the mentally deficient were institutionalized not primarily for the benefit they might obtain from the care they received but for the protection of others. Relatively recently and indeed largely in the past twenty-five years, a less alarmist and more optimistic view of the situation has lead once again to focussing the attention on possibilities of therapy. Modern treatment however no longer is based on the concept that in mental deficiency the sole difficulty is an intellectual retardation but rather on the broader concept of the individual as a functioning psychological unit in the integration of the multiple phases of which many factors must play their parts. Perhaps this is only an indirect way

(Presented before the meeting, held on May 3, 1949, at Edgewood Sanatorium, Orangeburg, S. C., of the Southeastern Society of Neurology and Psychiatry.)

of saying that mental deficiency which for generations has been regarded as one condition readily identifiable by a single reliable psychological examination, is in reality a group of social maladjustments which differ widely from one another in etiology, pathology and prognosis in spite of having the common denominator of a lower I.Q.

While of necessity a low intelligence quotient has constituted the passport for admission to the public institutions, private special schools have allowed considerable more latitude in their requirements and have accepted many children of average or even superior intelligence when it has seemed that these children could derive benefit from the special facilities which the school offered.

For various reasons which will be mentioned later, even a low I.Q. may not be an infallible guide, so that public as well as private special schools though especially the latter, are attempting to care for an extremely mixed population. At the one end of the spectrum of case material is to be found the defective who is so helpless that maintenance consists essentially in nursing procedures and general hospital care: somewhere towards the center would come the ordinary trainable or semi-adjustable group, while towards the other extreme are the emotionally disturbed, neurotic and borderline psychotic in whom the intelligence level may be normal or even superior, but whose behavior places them in an institution. At the left or lower end of such a spectrum, the I.Q.'s will be the lowest, and the chances of recovery least, while as we move towards the right or upper extreme, the I.Q.'s will be higher, and the possibility of adjustment greater: it should be noted however that this relationship is not a direct correlation, for it is well known that the prognosis of childhood schizophrenia in which the intelligence is sometimes high is extremely poor while many mental deficient without a personality disorder can be trained to make a satisfactory social adjustment.

As the preceding statement suggests, there is coming into being a new attitude on the subject of the populations of special schools, a viewpoint which has been reached by a more exhaustive study of the material, and which has been extremely well summarized by Kanner in a recently published monograph. In this article the author points out that the inhabitants of special schools belong not to a single category, but to at least three, which it is important to differentiate from the practical aspect of prognosis and treatment. The first group suffer from what Kanner calls "absolute feeble-mindedness" and includes "individuals so markedly deficient in their cognitive, affective and constructively conative potentialities that they would stand out as defective in any existing civilization." They are indeed so limited in practically every respect, that there is no reason to believe that by any treatment or training could they be made self sustaining at any period in their lives, and it seems certain that they will require custodial care for an indefinite period.

Idiots and imbeciles of the standard classification, victims of traumatic, infectious and vascular accidents, and developmental anomalies, form the bulk of this group.

From the standpoint of the physical consulted by the parents of such a child, recommendations for care will be based primarily on the family situation. The attitude of the parents towards the patient, the presence of other children in the family, the possibilities of the home as regards adequate supervision all will have to be taken into account and weighed carefully. It may be possible to retain the child in the home under favorable circumstances, but in the vast majority of cases, institutional placement will be the better solution. Here there will arise the question as to the choice of a public or a private school, and the decision must once again take into consideration a number of variables, such as the quality of care available in the institutions at the family's disposal, their own wishes, and their financial circumstances. There are many public institutions which provide excellent and adequate custodial care, and have the advantage of permanance and low cost. Certainly no physical should advise, or is possible to prevent it, allow a family to impoverish themselves and deprive other children of education or social advantages, merely to provide a temporary period of comparative luxury for a defective child in whom there is no legitimate hope of producing a satisfactory amelioration of the symptoms. Private schools should and usually do provide much more in the way of individual care and personal attention and in this respect may play a useful role provided all concerned have a full knowledge of the meager results to be expected in the form of improvement. Assuming however that life long care is required, that the family can make the necessary emotional adjustments, and that there is available a good public institution, it offers probably the most satisfactory solution in the majority of instances.

Kanner's second classification is what he calls "Relative Feeble-mindedness" or "Intellectual Inadequacy." He defines the group as composed of "individuals whose limitations are definitely related to the standards of the particular society which surrounds them," and he points out that it is not enough to ask whether such a person is inadequate, as though the term had an absolute meaning, but to define the conditions to which he is inadequate. Primarily, of course, it is the intellectual sphere which is implied—the individual may not be able to do the schoolwork normally expected of his age and development, but he may be perfectly adequate and even an extremely useful member of society as a farm hand or factory worker. In some instances it is the determination of parents to place the child into some preconceived niche in the social structure for which he is totally unfitted that causes the inadequacy to appear, in others it is the general structure of the local society which by its involved complications precludes an adjustment which might be made satisfactory in a

simpler environment. In this group Kanner believes that a great deal can be done by training and guidance of the individual and by manipulating or changing the surroundings, and he feels that many of its members can be established independently with judicious placement.

The task of the physician consulted by a family with a child of this group, will not be easy. As has been pointed out, it may be possible, in some instances to arrange an environment in which the individual can function adequately without any special school training, and if practicable it is of course desirable. Such planning will involve considerable time on the part of the physician in discussing the situation with the parents and the child: it will require detailed knowledge of the entire life situation of both, and a familiarity with the local environment in which the child is to be placed. Often however there is a need for the specific occupational training best given in a special school, which can at the same time assess the individual's abilities, and guide him in the direction in which he will become best adjusted. If it is primarily vocational training which is indicated, many public institutions do an excellent job, and indeed might be preferable to some private schools which tend to emphasize cultural rather than practical development: but if on the other hand the attempt to fit the child into his own social sphere is justified and if in this sphere he would normally be surrounded by others who have had certain cultural advantages, the private special school can fill a useful function.

The third category of Kanner's classification is that of "Apparent or Pseudo Feeble-mindedness," meaning "individuals who appear to be limited at the time of the psychometric rating but who at other times, under different circumstances or after effective removal of the cause attain much higher I.Q.'s—average or better." It is common knowledge of course that during severe emotional disturbance, intelligence as determined by standard tests often is seriously impaired, only to improve when the emotional upset has passed, and probably everyone who has worked with disturbed children has seen such cases in which the I.Q. may rise ten or twenty points in a few months. Admittedly these are the exceptional instances, and it is more frequent to find situations such as those enumerated by Arthur in which a special disability in reading or arithmetic for example has been confused with a general disability, in whom delayed speech has not prevented the development of non-verbal abilities, those with impaired vision or hearing or those in whom an early illness delayed but did not prevent mental development.

Perhaps it would not be improper to include here too, at least for the purposes of the present discussion, those who are referred to a special school, usually private, not because of intellectual failure in terms of I.Q., but because they could not get along at regular schools due to character disorders, neurotic traits or

behavior characteristics which usually become especially evident in the adolescent period. Schizoid and schizophrenic illnesses, obsessions and situational or compulsive activity anxiety, and negativism are common in this group in our experience. In this category particularly the principal concern is not that of custodial care nor even of training and guidance: it is one of thorough investigation and diagnosis, with the hope that adequate therapy of whatever type indicated may succeed in removing the handicaps that are preventing the full development of the personality. These are the cases which require individual and painstaking study and will in many instances richly repay the time and effort invested.

The selection of a special school or other institution for a child of this type will then depend most vitally on the ability of the organization to provide the utmost in clinical investigation and in modern therapy. First and of fundamental importance is the presence of a trained and forward looking staff, keen in their work and interested in the problems of rehabilitation and treatment. Obviously all the disciplines of psychiatry, psychology, medicine, and pedagogy should be adequately represented, and even more important clinicians in these fields should be in sufficient force, and sufficiently free from administrative duties to be able to give adequate individual time to the study and treatment of each case. Such a team working together will hold meetings at which information will be pooled and diagnostic and therapeutic measures considered; they will also give instruction and guidance to other members of the staff such as the housemothers and fathers who come in closest contact with the child from day to day, and they will see that plans for treatment outlined by the group are carried out or modified as indicated. While it is not an absolute essential, it is generally true that the group will be more alert if the individual members are responsible for the instruction of students, and have some outside teaching affiliations in medical schools or elsewhere.

Necessarily, the equipment of a school which plans to handle this type of case will be far more elaborate and extensive than that usually considered adequate in a special school. In addition to all the ordinary facilities for training such as schoolrooms and workshops, there should be available complete laboratory service, facilities for consultation with established specialists in related fields of medicine, psychology and pedagogy, and the equipment necessary in the detection of special disabilities and for the training required to eliminate them. All forms of psychiatric therapy including facilities for insulin and electric shock, and brain surgery should be either available in the institution or readily accessible. The occasional incidence of brain tumor, or other remediable cerebral pathology should not be overlooked.

In order to be more specific, it might not be out of place to describe the procedures related to the treatment of a child in our own school. These are sub-

mitted not with the presumption that they represent perfection in any sense, but because they have been evolved as a result of many years of trial and error experiment, and because the methods are practicable and efficient and yield the satisfactory results. They are however not set forth as the final word and are undoubtedly subject to further modification and refinement.

Our sole criterion for admission is the assumption that without particular facilities, we can be of help in a given case. Since prospective students are invariably referred by physicians or other competent experts, we are usually able to have in advance abstracts or copies of records which serve as a preliminary orientation, but in every instance before actually enrolling a child we insist on an interview with the parents or guardians, and on making an examination of the child. The latter investigation consists of a visit with the psychiatrist, the psychologist, the physician or all three, and on this basis, if the child is accepted, placement is arranged in a unit, the supervisors of which have been given a brief sketch of the problem, and provisional recommendations for handling the situations which might be expected to arise. In general this procedure seems preferable to the use of an admission building, and while there are of course exceptions, the adjustments period seems to be easier when it is with the group, than when it is complicated by a period of isolation. To forestall the possibility of an infectious disease being brought in, a brief physical examination is made immediately.

A careful detailed psychiatric history covering the entire development of the child is begun at the initial conference, though it may take more than one sitting to complete, and as a by-product may lead to modifications of the program tentatively planned. Programs for instruction in specific disabilities are usually arranged at this point. Meanwhile the child is encouraged to make himself at home in the unit, to take part in the activities naturally and to make friends with the others. Often but not invariably an older student is assigned as a buddy or big brother or sister.

For the first day or two little formal examination other than the detailed physical work up including laboratory tests is attempted, since it has proved better as a general rule to give the child a chance to adjust to the new environment. During the initial week, one or more psychiatric interviews have been undertaken, and the psychological tests which include standard I.Q.'s as well as academic tests like the Stanford, and usually personality or aptitude tests have been started.

Usually by the end of the first week enough data has been gathered from the history, the psychiatric, medical and psychological examinations, and the observations of the house and school staff to make a more detailed formulation, with a tentative diagnosis, a prognosis, and much more important recommendations for therapy. These include such items as medical treat-

ment, diet, exercise, academic and social activities, psychotherapy of whatever type indicated, and special instruction such as reading or speech.

The whole individual program is of course reviewed and if necessary modified at stated intervals, and may be altered at any time if some special problem arises when any necessary additional testing procedures may be ordered, and appropriate changes made in therapy or environment.

It goes without saying that the staff objective is to return the child to a regular school, or to society as soon as possible, so that it is essential to think in terms of how soon this may be accomplished. In the periodical reviews of case material, this point is frequently discussed and as soon as a sufficient margin of safety is considered to be established, the family is aided in making plans. Incidentally one of our most serious problems is that most of our parents live so far from the School that the frequent interviews which would be so desirable often have to be omitted or at best covered inadequately by correspondence, and one of our dreams has been the establishment of a "Parentorium" in which parents could live for a time close by, interview the Staff, and follow the progress of their child.

The following case histories, while not typical of the group, are not unusual in our experience:

William was an 11 year old boy who was referred to the school because his obscene language and violent aggressiveness made it impossible to keep him in his home or any ordinary school. The behavior had dated from about a year before enrollment, and was considered by the parents to be due to undesirable associates; and it was only when they moved to a new community and found that the boy was not changed and when outpatient clinic treatment had proved unsatisfactory that the decision was made to try residential care.

William's birth was normal and his mother insisted that while he was not a planned-for baby, he was a welcome addition to the family, though there was no doubt that his only brother, who was two years older, was very much better accepted than William. He was bottlefed from the start. At the age of one year he developed a severe throat infection which necessitated tracheotomy and intubation and was in the hospital for six months and later at his grandmother's and away from the remainder of the family. When he was home much of his care devolved on nurses. He got along satisfactorily in kindergarten, poorly in first grade and badly in succeeding years.

The father was one of the younger sons of an aristocratic and wealthy family; he had had a serious accident early in life, as a result of which he always had been "nervous" and though of apparently at least average ability had never settled down to any continuous and productive work, and had moved many

times. At the time the boy came into this School, the family was living on a farm. Alcohol had played some part in the father's history but was apparently not a factor during the present episode. The mother stated of herself that she was strict with the children, undemonstrative and had many outside interests which she felt were more important than the family.

Physically William was well developed and in apparent good health. Special eye and cardiac examinations were negative and an electroencephalogram showed "marked lability and high voltage" which were felt to indicate probable behavior difficulties. On the Standard I.Q. he obtained a rating of 107 at admission and the Rorschach supported the impression of the electroencephalogram about his emotional instability. In addition he had a specific reading disability and could not pass even the first grade reading tests. The outstanding feature of his character however was his attitude of intense hostility and aggression which was evident not only in his behavior but also in his fantasy and play life which were invariably concerned with fighting and killing enemies. From a psychiatric point of view it was evident that the aggression and hostility were related to a feeling of rejection and inadequacy, and emphasis was placed on the attempt to develop satisfying emotional bonds with others. Psychotherapy was not intensive, but supportive, and carried on at widely spaced interviews. Special training in reading was instituted and William was encouraged to be a leader in physical activities which he did very well, becoming a team captain. With the special instruction mentioned his school work and reading improved and in two years on the Stanford Achievement his grade rating improved from 2.2 at the beginning to 4.1 despite a severe illness requiring hospitalization for several weeks. His I.Q. increased from 107 to 117. He was much better emotionally adjusted, could visit at home without getting into trouble and was much happier and more relaxed. In view of his very obvious gains the family anticipated our recommendations by having him try entrance examinations for a regular boarding school at which his brother was a student. He did well and was accepted and apparently for the past two years has been carrying the regular curriculum.

This case illustrates the type in which a suitable understanding environment with specific attention to definite disabilities produce results without the use of elaborate psychotherapy. In the following instance, the psychotherapy would seem to be the important factor though it is to be noted that this psychotherapy was carried out in the particular environment of the school, and that because of the patient's condition, it could have been attempted otherwise only in a hospital situation.

When Charles, age 18, came to the School he was under the influence of a narcotic, which had been administered by the referring physician when he was unable to persuade the boy to leave his home. Ap-

proximately six years before admission Charles had developed anxiety attacks in which he was afraid to be out with others or to leave the house. At first he was able to conceal these from his family and friends, but they gradually increased in frequency and intensity until he was unable to attend school or even to leave the house, and had lost two years academic work. Although perfectly clear intellectually, he was in a constant state of panic and tension, to which the family had reacted at first with kindness and persuasion, but more recently with force, eventually physically removing the boy from his room. As long as he had attended High School he had had an excellent record, was popular and a good athlete.

This case obviously presents a problem distinctly different from the preceding. Psychotherapy here is the obvious method of choice and it was employed in a series of interviews in the usual type of exploratory discussion. No attempt was made to interfere with his compulsive behavior which kept him restricted almost exclusively to the school building and his living quarters. Eight months after admission he was so much improved that he talked cheerfully about going to the Camp in Maine for the summer, and a month later boarded the bus and train without any difficulty. During the summer he took part in every activity, went everywhere and voluntarily made up part of the studies he had lost. In the Fall he was enrolled in a preparatory school where he did a year's work in six months; he then registered at the engineering school of a good university. In his freshman year he not only did well academically, but made three of the athletic teams; he continued to do well his sophomore year and made the football squad. There have been no recurrences of his symptoms, in spite of the fact that as far as it is known he has had no further therapy. It is impossible to estimate the relative effects of the therapy and the school environment, but at least the combination seems to have proved effectual, when therapy alone attempted in the home had been unsuccessful.

It may be argued that the picture presented above is that of a hospital rather than a school and it does seem to be true that the special school is being called upon more and more to fill the place in child psychiatry which is in the adult field occupied by the open psychiatric hospital. The school setting is after all the most natural one for most growing boys and girls and there should be no reason why it cannot be used and implemented by the advantages inherent in the controlled residential situation, to give psychiatric care not only in its environmental aspect, but also in various forms of pure psychotherapy including intensive interviews or analysis where indicated.

The referring doctor has every reason to expect and should demand that in a reasonable time after the admission of his patient to a special school he would receive a report outlining in detail the results of a complete examination and evaluation by a group of

competent specialists covering the psychiatric, psychological, medical and educational status of the patient, giving at least a tentative diagnosis and prognosis and including recommendations and the proposed plan for treatment, just as he would expect a similar report from any other expert or group of experts to whom he referred a patient. These preliminary reports should of course be followed at suitable intervals by progress notes. It is high time that the special school assumes its responsibilities and accords the re-

ferring physician the kind of cooperation he deserves.

Perhaps even a few years ago this would have sounded like wishful thinking about an unattainable ideal; today it is being put into the realm of practical achievement.

REFERENCES

Kanner, Leo: Feeble-mindedness: Absolute, Relative and Apparent *The Nervous Child* Vol. 7, No. 4 1948, p 365-397.

A New Antihistaminic—Chlor-Trimeton Maleate

J. R. ALLISON, M. D.
A. M. ROBINSON, M. D.
Columbia, S. C.

°Chlor-Trimeton maleate is the newest of the antihistaminic compounds. In the thirty-six cases which we have used this drug, we have found it to be more effective and less toxic than any of the previous antihistaminics. Chlor-Trimeton maleate is the maleic acid salt of a new compound derived from the antihistaminic substance, Trimeton. Chlor-Trimeton maleate has markedly increased pharmacological activity as compared with the parent substance.

The required dosage appears to be 2 or 4 mg. three times daily, which is approximately 1/20 of the dosage used in Trimeton or the other related antihistaminics. Of the thirty-six cases in which this drug was used we observed only one in which any toxic effect was noted. The patient complained of paresthesia generally, which subsided upon cessation of the drug.

SUMMARY

1. An appraisal is made of the clinical value of Chlor-Trimeton maleate.

2. This compound is antihistaminic, inhibits histamine and antigen whealing, and benefits the symptoms of allergic manifestations.

°Chlor-Trimeton maleate was supplied by Schering Corporation, Bloomfield, New Jersey.

Table 1.—Clinical Results With Chlor-Trimeton Maleate

	Total Patients	Satisfactory Relief	Toxic Effects
Dermographism	3	3	0
Atopic Eczema (adults)	4	1	0
Atopic Eczema (infants)	3	2	0
Urticaria	7	6	0
Angioneurotic Edema	5	4	0
Asthma	2	1	0
Seasonal Hayfever	5	5	0
Vasomotor Rhinitis	3	2	0
Dermatitis Venenata (rhys)	2	1	0
Pruritus Vulvae	1	1	0
Neurotic Excoriations	1	0	1

3. As compared with some of the older antihistaminic compounds, smaller dose (2-4 mg.) may be used for therapeutic effects.

4. We commend the use of this drug because of its extremely low toxicity and high therapeutic effect.

REFERENCES

1. Teslow, R., and others: *Fed. Proc.*, 1949, in press 35.03 90517

**TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION**

1949

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

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A. M. A. CLINICAL SESSION

The Clinical (Mid-year) session of the American Medical Association will be held in Washington, D. C., December 6 to 9. Instituted only recently this, winter session of the A. M. A. has become extremely popular, particularly to those who are engaged in general practice. The papers, addresses, and discussions are all of a clinical nature and are aimed toward the practicing physician.

It will probably be a number of years before this session is held as close to South Carolina as it is this year. We would urge every physician who can possibly do so to go to this meeting. Not only will he have the privilege of attending the various sessions but he will have ample opportunity to go through the commercial and scientific exhibits, which is a post-graduate course in itself.

Should any member of the S. C. Medical Association attend the meeting and want to sit in on one of the sessions of the House of Delegates of the A. M. A., as an observer, this can be easily arranged. The meetings are held at the Hotel Statler and are open to visitors, except for the occasional executive session. The two delegates from South Carolina, Drs. Hugh Smith and Julian Price, will be glad to have them present and it would give them pleasure to introduce them to their friends.

A RUT

Nowhere have we heard a better definition for a rut than that given by a minister in years gone by. "A rut is simply a grave without the ends." Carrying his step farther, we might observe that "to get into a rut" is to dig the two sides of one's own grave.

In every walk of life there is a tendency for an individual to get into a rut in his daily work and daily thought—and this is noticeably true of those of us who are engaged in the practice of medicine. The surgeon tends to think in terms of the scalpel and hemostat and to lose interest in those conditions which

are not amenable to surgical care. The internist, beset by patients with chronic complaints and imagined ills, tends to consider every individual who comes into his office a psychoneurotic. The otolaryngologists, confronted with countless cases of upper respiratory disease, tends to feel that the basis of all disease lies in the tonsils or sinuses and that if all is well with these portions of the anatomy, the world will sleep in peace. The general practitioner, glorying in the results which have been obtained through the use of chemotherapeutic agents and antibiotics tends to consider a dose of sulfa or a shot of penicillin a sure cure for any and every ailment. The pediatrician, constantly seeing the inroads which are made against good health by an inadequate diet and poor hygienic conditions, tends to believe that all that is needed to make the next generation stalwart beings is an adequate supply of food and accessory vitamins.

But it is not only in the realm of his everyday medical work that the physician tends to get into a rut. Even more deadening is the tendency for him to think of his community and of his country in terms of his own work and his personal interests. An executive of the Boy Scout movement comes to him and asks for his active participation in the organization of which the physician's own son is a member; the chairman of the Community Chest campaign solicits his help in the annual drive; a leader in his community asks that he meet with a group to study much needed civic improvements and to formulate plans for the future; the church of which he is a member is planning an enlargement program and he is urged to serve on the steering committee; officers of his state medical association call upon him for assistance in the program which they are trying to develop—and to each and every appeal he tends to give his stock reply, "I am sorry but I cannot do it. I am so busy with my everyday work that I do not have time for these other things." What he is really saying is, "I am so satisfied with what I am doing in my own little sphere that I have lost all sense of responsibility and all interest in the affairs of my community and of my state. I am in a rut—and I refuse to get out."

If the physician is to assume his rightful place as a

citizen and as a member of society he must tear down those walls of self-interest and self-complacency which tend to hem him in and raise his eyes outward and upward—outward to his fellow-man, upward to the stars. In no other way can he prevent the rut from closing in at the ends and burying him in a mental, social, and spiritual grave.

MEMBERSHIP IN COUNTY SOCIETIES

Here is the membership of the Association by counties:

Abbeville	13
Aiken	14
Allendale	8
Anderson	57
Bamberg	8
Barnwell	5
Beaufort	5
Berkeley	6
Calhoun	4
Charleston	134
Cherokee	10
Chester	11
Chesterfield	11
Clarendon	6
Colleton	10
Darlington	16

Dillon	12
Dorchester	5
Edgefield	7
Fairfield	7
Florence	51
Georgetown	7
Greenville	132
Greenwood	25
Hampton	5
Horry	18
Jasper	2
Kershaw	12
Lancaster	6
Laurens	17
Lee	6
Lexington	12
McCormick	1
Marion	14
Marlboro	15
Newberry	19
Oconee	11
Orangeburg	30
Pickens	17
Richland	171
Spartanburg	88
Saluda	5
Sumter	27
Union	13
Williamsburg	14
York	36

DEATHS

JAMES OSCAR SANDERS

Dr. James Oscar Sanders, well known and beloved physician of Anderson, died suddenly of a heart attack in his office on September 22.

Born in Horry County, Dr. Sanders moved to Anderson County at the age of ten. Following attendance upon the schools in that county he continued his education at Clemson College and the University of Maryland School of Medicine. In 1900 he opened his office in Anderson for the general practice and was actively engaged in this type of work up to the time of his death.

Dr. Sanders was a real family physician, one who not only took time and interest in his patient's welfare but who was also concerned with the work and problems of his community and of his church. At the time of his death he was recognized as one of Anderson's finest citizens and most loved individuals.

Dr. Sanders is survived by his one son, two daughters, two sisters, and six brothers—three of whom are physicians, Dr. J. L. Sanders of Greenville, Drs. R. L. and Carl Sanders of Memphis, and one a dentist, Dr. Mac Sanders of Anderson.

WILLIAM CLINTON MARETT

Dr. William Clinton Marett of Seneca died at his home on September 28, following a lingering illness.

After receiving his medical education at the University of Maryland School of Medicine (1911), Dr. Marett started his practice in Seneca. He served as a captain of Ambulance Co. No. 2 of the First Division during the World War. He was a charter member of American Legion Post 120, and was an elder in the Presbyterian Church. Poor health forced him to give up active practice several years ago.

Dr. Marett is survived by his wife, three daughters, and one son, Dr. W. C. Marett, Jr. of Oliver General Hospital, Augusta, Ga.

HERBERT M. SMITH

Dr. Herbert M. Smith, retired physician, died at his home in Columbia on October 11.

A native of North Carolina, Dr. Smith received his medical education at Johns Hopkins (1901). In 1911 he moved to Columbia, served as county health officer for two years and then took a position with the State Board of Health where he served for 29 years, 25 years as Director of the Laboratories Division. Several years ago ill health forced him to retire.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

PHYSICIAN AGREEMENTS BEING SIGNED

There have been mailed within the past few weeks to every doctor of medicine duly licensed in South Carolina, a copy of the fee schedule of the South Carolina Medical Care (Blue Shield) Plan, together with a form of the agreement for execution by him, between the Plan and participating physicians. There are in the State approximately 1500 licensed physicians in active practice, of whom slightly in excess of 1100 are members of the South Carolina Medical Association. Under the terms of the Enabling Act, at least 50 percent of all the doctors in the State must be enrolled as participating physicians before the Plan can operate. It is therefore essential that the doctors give consideration to this matter immediately, and that they execute and return the agreements promptly if they expect to participate.

There is no doubt of the general approval of the Plan and the fee schedule by the membership of the Association as a whole. The unanimous acceptance of the plan of organization, the By-laws and fee schedule by the House of Delegates at the annual meeting in May, is sufficient indication of that. There may be a real danger, however, of delay in getting started, simply because of lack of interest or inattention. For that reason, we have undertaken repeatedly before (and we now do so again), to bring this to the attention of the doctors and to urge that they take a little time to attend to this necessary detail.

More frequently than would seem possible, we hear expressions from physicians to the effect that they are totally unfamiliar with the Plan and unaware of its provisions. The matter has been fully covered in this Department of the Journal in past months and the office has invited repeatedly, inquiries for additional information. The following brief resumé of what has been published may be of benefit to those who missed the particular issues in which the different phases of the Plan's operation were discussed:

In the February 1949 issue of the Journal, beginning at page 52, the By-laws of the Plan were carried in full. In the same issue, on page 49, there was a brief report of the action of Council at a special meeting on January 16th, adopting the report and recommendations of the Committee on Medical Service. This account carried a general statement of the plan of operation.

In the March and April issues there were brief reports of the work being done by committees in connection with the preliminary organization and preparation of the fee schedule.

Following its approval by the House of Delegates on May 17th, the fee schedule was carried in full in the June issue, beginning at page 185.

The August issue, page 255, carried a report of the issuance of the Charter to the Plan, and following this, the first of a series of questions and answers designed to develop as fully as possible information concerning it which the members of the Association should have. A second series of questions and answers, designed for the same purpose, was included in the September issue, page 288, and we have gone so far as to volunteer to undertake to provide the answers to additional questions which might be suggested by the individual physicians.

The October issue of the Journal carried a report of the meeting of the Board of Directors, adopting the contracts and fixing subscription rates, and also, in full, copies of the agreement between the Plan and participating physicians, and the subscriber's certificate.

Members who may have missed any of the foregoing may refer to their old Journals for the information indicated, or if those numbers have been misplaced, the office of the Association in Florence will be glad to comply with any requests for information.

If the Plan is to begin operation on January 1st, as now proposed, the cooperation and active interest of the physicians, as indicated above, is necessary at this time.

THE GREAT INVESTIGATION

The announcement early in October of the investigation launched by the FBI into activities of medical associations and health insurance plans was not unexpected. A few days previously a wire from Chicago had been received in the offices of the State Association requesting information as to whether such investigations had been commenced in South Carolina. All County Society Secretaries were contacted but no such activity here has been reported to date.

A few weeks before, there had been an intimation or an outright statement by an agent of the bureau, in one of the mid-western states, to the effect that such a "nation-wide" investigation impended.

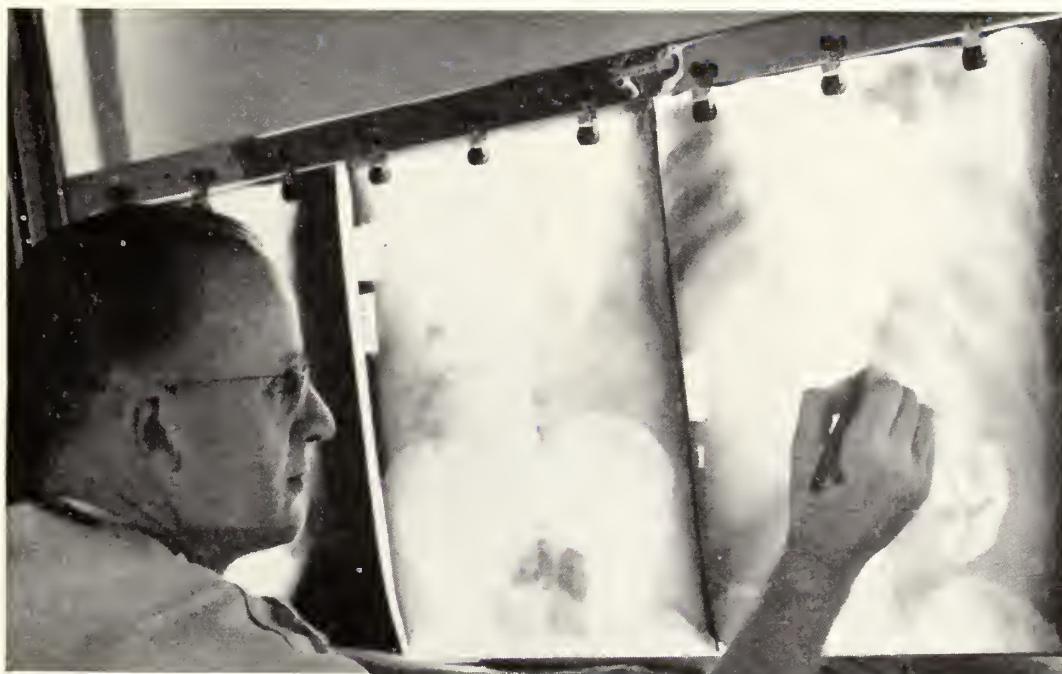
The investigations, being handled by the FBI, and therefore under the jurisdiction of the Department of Justice, and the Attorney General, Howard McGrath, former U. S. Senator from Rhode Island, and former Chairman of the National Democratic Party, and also staunch adherent of the proposals for Compulsory Health Insurance, purport to involve possible violations of the Sherman Anti-Trust Act, which provides criminal penalties.

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RESEARCH IN THE SERVICE OF MEDICINE

The fact that the investigations have taken this course is strongly indicative of the motives by which they were prompted.

There is another channel through which the Government might have proceeded if there had been any real basis for investigation of activities of the sort implied. The Federal Trade Commission was established and exists for the precise purpose of furnishing the necessary machinery and facilities to prevent and terminate improper combinations in restraint of trade. The Commission was established in 1914 during the administration of Woodrow Wilson and, therefore, is of genuine democratic origin—at a time when the Democratic Party occupied a decidedly different status from that which it occupies today.

But the Federal Trade Commission does not carry out its decisions by means of criminal process. Its procedure is entirely administrative, or to use a legal expression, on the civil side of the court. Upon receipt of a complaint, however unimportant the source, or at its own instance, the Commission is authorized to investigate probable combinations which tend to restrain free competition in commerce or trade, and it has at its disposal ample staff and facilities for a complete and thorough-going investigation. The law provides for assistance through court order where this is necessary, to gain access to the files of the person or firm under investigation. If probable cause is found, a complaint is issued, but the Commission, after hearings, and upon making its decision, proceeds not through a criminal prosecution, but by means of a stop order, requiring the offending party to "cease and desist" from its unlawful practices.

The Federal Trade Commission, although it does have somewhat of a record for lengthy and almost interminable investigations, has also effectually handled more than one combination in restraint of trade, being largely responsible for the breaking up of the Trust represented by the original American Tobacco Company, many years ago; and for the modification if not the complete breaking up of the "Pittsburg Plus" price system, which existed for many years in the steel industry, headed by the industrial empire which was and is United States Steel.

But such procedure obviously would not have served the purpose of the "powers that be" in the present instance. Had there been any real necessity for Government to act to terminate improper practices which tended against the interests of the American people, or an appreciable group of them, the logical procedure to have taken would have been through the Federal Trade Commission. But this would not have been sufficiently dramatic; it would not have arrested the attention of the people generally; it probably would have passed largely unnoticed; it certainly would not have tended to hold up the medical and affiliated organizations as possible violators of criminal statutes of the United States, requiring the attention of no less

an effective department than the noted FBI.

The purpose is obvious, but we believe the result will disappoint the politically ambitious individuals responsible for it, for despite the vilification leveled at the profession, generally, by its critics among the politicians within the past few years, the doctors as a group rank among the highest in the professions, and when the investigations fail to develop any information providing a basis for just charges as to any restraint of trade, or other unlawful practice on the part of the members of medical associations and non-profit insurance plans, the public reaction to the high-handed, unnecessary, strong-arm tactics taken will undoubtedly be in favor of, rather than against the medical profession.

INVESTIGATION PROVOKES EDITORIAL REACTION

Some idea of the public reaction to the FBI investigations recently launched into the activities of various medical associations and affiliated organizations can be obtained from the following reprints from the editorial pages of the newspapers referred to:

LOS ANGELES TIMES

October 8, 1949

The AMA Singled Out

Though no announcement of the fact was made by the Department of Justice, it appears reasonably certain that the American Medical Association is under investigation by the Federal Bureau of Investigation and the Antitrust Division. It is hinted that asserted monopolization of hospitals by AMA members is the particular subject of investigation.

It may occur to the general public that if the American Federation of Labor, which openly proposes to raise a large campaign fund to defeat certain members of Congress, and particularly Sen. Taft, is not investigated, then the AMA, which has sought to raise a much smaller campaign fund to protect itself from what it considers an assault on medical standards, ought not to be investigated either.

"The Department of Justice has made no move to investigate the United Mine Workers, whose virtual monopoly of coal mining is obviously far more hurtful to the public than anything the AMA does or attempts. The AMA's influence over hospitals purports to be in the public interest, and a case can be made for the theory that it is. Perhaps in some cases a qualified physician or surgeon may be barred unjustifiably from some particular hospital; but the number of times that unqualified men are justifiably prevented from practicing must be far greater. Only if it were shown that AMA membership, in itself, is a passport to hospital practice, and without regard to other and more important qualifications, could the control be attacked as unreasonable.

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Bibliography: 1. Ware, H. H., Jr.: Virginia M. Monthly 70:238, 1943.

Ortho

Cleveland
THE PLAIN DEALER
and Daily Leader
October 8, 1949
THE POLICE STATE

Has the police state come to this country? Of course not. It couldn't happen here, or could it?

Maybe it is just a coincidence that the antitrust division of the Department of Justice is investigating the American Medical Association and 16 other state and county medical societies.

Somebody broke into the board room of the trustees of the American Medical Association in Chicago last February and ransacked the records. That couldn't have been anyone connected with the government, else why would the FBI be going through the records now? The trustees of the association have revealed that the FBI wants to see all records going back to 1938 and copies of all speeches made by AMA officials since then.

It happens, however, that the American Medical Association is conducting a nation-wide campaign against President Truman's compulsory health insurance program. In a police state, when anybody opposes the government, the police move in and cart the objectors off to jail.

That hasn't happened here—yet. The federal police have moved in, but they haven't carted anybody off to jail—yet.

Maybe the suspicions of the Department of Justice are well founded. The FBI may find evidence that the medical association has been violating the antitrust laws because it restricts its membership to those who conform to certain standards and who have passed examinations conducted by state boards. If so, then the FBI might also find that bar associations, dental societies, professional engineers, barbers, cosmetologists and all other organizations whose members are licensed by the states also were in violation of the antitrust laws.

Could it be that the Department of Justice is trying to get something on the American Medical Association because it is leading the fight against socialized medicine? What a ridiculous idea! President Truman and Attorney General McGrath wouldn't allow our government to employ police state methods, or would they?

COLUMBUS EVENING DISPATCH

October 7, 1949
Shocking Abuse

Action of the antitrust division of the U. S. Department of Justice in "investigating" county and state medical societies affiliated with the American Medical Association is a shocking misuse of federal authority.

And if the Justice Department agents are responsible for the breaking into and entering the board room of the AMA trustees in Chicago and searching

of its records, on last February 10, this move represents a new low in government morality even for an administration which has displayed a notable lack in that respect.

The reason behind this obviously political persecution of one of the nation's most respected professional groups is childishly transparent. The AMA has vigorously opposed President Truman's state medicine proposal. Therefore, the doctors are to be put on the spot, smeared in the eyes of the public and harried by government minions in the hope that they may choose the lesser of two evils and bow to socialized medicine rather than face possible trial in the courts on antitrust charges—however remote may be the likelihood of making such an absurd accusation stick.

By what possible stretch of the imagination can medical societies be properly condemned as combinations in restraint of trade? Or as illegal combines banded together to fix prices?

Unqualified persons are forbidden to practice medicine by law. The statutes lay down the qualifications. If there is any restraint, it is the government that imposes it. As for fees, every physician is his own arbiter in this respect. Medical societies are merely loose, professional organizations primarily dedicated to the interchange of data for the benefit of all their membership. If medical societies are in violation of the antitrust laws, so are bar associations and engineers' societies and professional groups of all sorts. It would make just as much sense to investigate the Democratic National Committee, but it isn't attacking socialized medicine, so of course that won't happen.

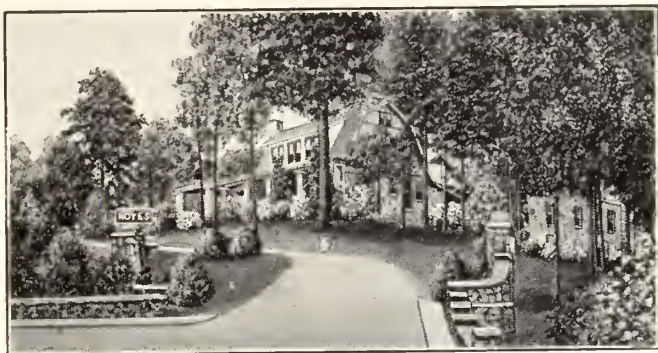
The Department of Justice would do better to investigate another breaking and entering job than to go into the burglary business itself. We mean the one out in Kansas City a few years back in which a Board of Elections' safe containing evidence of voting frauds was plundered while the president of the United States slumbered peacefully a few blocks distant in the Muehlbach Hotel.

THE WALL STREET JOURNAL

October 10, 1949
Monopoly Guaranteed

The Department of Justice is investigating the American Medical Association and fifteen local groups for alleged monopoly. The A.M.A. angrily retorts that this is using a "police arm" of government to "terrorize physicians into abandoning their opposition to compulsory health insurance."

We can vouch neither for the merits of the investigation nor for the truth of the A.M.A.'s counter-allegation. Certainly the "coincidences" the A.M.A. cites—such as the present Attorney General's sponsorship in Congress of the administration's compulsory health program—are suggestive. And certainly the Department of Justice, in confusing, as it often tends to, bigness with monopoly, doesn't exactly demonstrate



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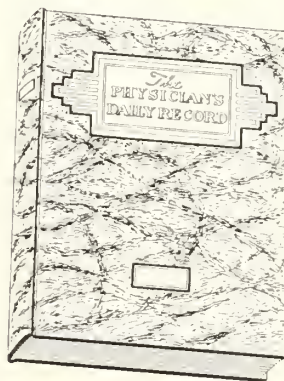
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that it is incapable of playing at least indirect politics.

But regardless of whether it is doing so in this case or not, the A.M.A. is on unquestionable grounds when it says *the administration's health scheme "would be a monopoly to which every citizen would be compelled to contribute."* In other words, the same administration whose trust-busters charge the medical societies with monopoly wants to create an absolute and unbustable medical monopoly.

CHICAGO DAILY TRIBUNE

October 11, 1949

WHO'S A MONOPOLIST?

On orders of Atty. Gen. McGrath, FBI agents are examining the records of the American Medical Association. The government is looking for evidence, said McGrath, that the AMA is "conspiring to restrain and monopolize the prepaid medical care plans not conducted under their sponsorship."

The same department of justice that is looking for evidence of a doctors' monopoly is wholly unconcerned about the demonstrated monopoly of labor in the steel and coal industries. John L. Lewis and Philip Murray have called strikes which have made more than a million men idle. Steel mills and coal mines are closed. If the strikes continue, most of the nation's industry will be paralyzed. Mr. Truman refuses to use the Taft-Hartley law to limit the damage done by these strikes, but he doesn't hesitate a moment to toss the whole statute book at the doctors who have never closed down any industry.

Lewis and Murray cannot be charged with monopolistic practices because unions are exempt from prosecution under the antitrust laws. If the members of the AMA were organized in a labor union and affiliated with the AFL or CIO they could run out of business all prepaid medical care plans which did not pay tribute to the AMA.

And no FBI agents could come snooping around looking for evidence of monopoly.

"WHAT ANEURIN BEVAN TOLD ME"

By John W. McPherrin

When I arrived at the Ministry of Health in Whitehall for my 4:30 p. m. appointment with the Minister, his courteous secretary, Mr. Beddoc, said that the Minister would see me in a few moments, and asked if I had enjoyed my stay in Great Britain. Before I had time to answer, a door opened somewhere and all of a sudden a big man with a shock of steel grey hair was at my side saying, "Come with me, we're going to some quiet place. My office is all filled up with photographers' equipment . . . We'll go to another room where we can talk." He linked his arm in mine and down the hall we went to a small secluded office.

° Reprinted by permission from the American Drug-gist, July, 1949.

This walk to the other office took only a few minutes, but the vitality of Aneurin Bevan registers fast. At once you are aware of the vivid personality of this man. You know that you are with a man of great personal power who intensely believes in what he is doing and has no fear of any opposition. By the time we reached the little private office, I was glad that it was my job to interview him instead of argue with him. He could be a rough, tough and brilliant antagonist.

And so we sat down for what was scheduled to be a thirty-minute visit, but thanks to the courtesy of the Health Minister, it was stretched to forty minutes. I began by explaining why I was in Great Britain.

"Mr. Minister, as you may have heard, our President, Mr. Truman, has proposed a health plan for America that is something like yours." The sharp blue eyes of this big Welshman smiled and he nodded agreement. So I went on.

"If we are going to have such a program, it seems to me that British hindsight on this subject could be much better than American foresight." The Minister smiled out loud at that point, but I think he liked it. "No one in the world," I continued, "could have had more experience than you in handling a health program of this magnitude. Therefore, I would like to get some answers from you to take back to America."

That was how the interview began. I must confess now that Minister Bevan beat this reporter to the punch and asked the first question.

"Tell me," said Mr. Bevan, "what do the chemists think of my plan? You've been around the nation calling on them. Tell me how they like it."

I was not surprised that Aneurin Bevan referred to the National Health Scheme as "my plan." He may not be the father of it, but he is most certainly the foster father and, therefore, has a right to some paternal feelings.

In answer to his question about the chemists, I replied that the chemists who had been doing less than the average volume were greatly helped by the increase in prescriptions and were very much for it, but that those who had a good business before the Health Service act were not so favorable. In all honesty I had to tell him that, although a majority of all chemists seemed to be for the Scheme, I did not think they were for it because of any noble purpose.

The Minister listened carefully as I explained that the most common reason given by small chemists shops for supporting the program was that it was producing more money than they had enjoyed before. The successful shops opposed the plan because it had ruined their large private prescription business.

Regarding the attitude of doctors on the Scheme, I reported that it followed the same pattern as the chemists. Those whose small incomes were increased were for it. The others were not.

In commenting on the attitude of chemists and doc-

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Alexander Brunschwig	OPERABILITY OF CANCER	N. Y. Memorial Hospital
Meredith F. Campbell	UROLOGY	New York
Louis K. Diamond	RH FACTOR	Harvard Medical School
Arthur C. DeGraff	HEART	New York
Maxwell Finland	NEW ANTIBIOTICS	Harvard Medical School
Richard H. Freyberg	COMPOUND E IN ARTHRITIS	Cornell University
Chevalier L. Jackson	BRONCHOSCOPY	Philadelphia
Herbert C. Maier	CHEST SURGERY	N. Y. Presbyterian Hospital
James F. Norton	EXTRA PERITONEAL CAESAREAN SECTION	Margaret Hague Maternity Hospital
Eugene P. Pendergrass	X-RAY	Pennsylvania Hospital
E. R. Pund	SMEAR DIAGNOSIS OF CANCER	University of Georgia
R. L. Sanders	BILIARY AND PEPTIC ULCER SURGERY	Memphis
Albert M. Snell	MEDICAL TREATMENT OF GALL BLADDER	Mayo Clinic
Walter G. Stuck	BACKACHE	San Antonio
Donald H. Stubbs	VASCULAR AND CIRCULATORY COLLAPSE	Walter Reed Medical Center
Oscar Swineford	ALLERGY	University of Virginia
Willard O. Thompson	USE OF ESTROGENS; OBESITY	Chicago
Richard W. TeLinde	CANCER IN SITU (cervix)	Johns Hopkins Hospital
Waltman Walters	GALL BLADDER SURGERY	Mayo Clinic
Julius L. Wilson	CHEST DISEASE	Tulane University
Harold G. Wolff	HEADACHE	Cornell University

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tors the Minister said, "The cash motive is the only important incentive in private enterprise, but is not the only one in modern society. The real motives of people are rarely understood. They react not only to the cash motive but to how their friends regard them. During the war, men did not become heroes for cash awards. They were heroes because they wanted to be well regarded at home." I asked if he thought this desire to be well regarded could be made as effective as the cash motive in peacetime. He replied that in time it could become even more important.

Our discussion of motives got us on to Mr. Bevan's pet subject: doctors as doctors and as members of organized medicine.

Because I had heard that Mr. Bevan and the BMA (British Medical Association) had locked horns several times, I wasn't too surprised at what I heard.

"Most people trust their individual doctors," began the Minister. "At least they trust them more than they do organized medicine, the associations of doctors. When a doctor becomes a member of an organized group something seems to happen to his thinking. Did you ever notice that? It is quite a phenomenon."

"The mental change that comes over a doctor when he functions as a member of organized medicine is unbelievable. It ought to be the subject of psychological research. You know that organized medicine has always been arrogant, always on the defensive. What are these doctors afraid of? Maybe they have an inferiority complex of some kind. It is all very surprising because, as individuals, doctors, most of them, enjoy the faith and confidence of the public."

That was not all that the Minister had to say about doctors, but it's enough to give an impression of his attitude.

At this point I decided to present a question which I think is important to all who sincerely want to find a right answer to health and other social problems.

"Mr. Minister," I began, "I agree that some stupid, thoughtless things have been done by some people in private enterprise, but if all people in private enterprise had been enlightened men of vision, maybe the government would not have had to take over control of health and other services." Mr. Bevan was listening very attentively. "Let us assume that this trend toward socialism began thirty years ago because of the mistakes of reactionary people in private enterprise. My question is how do you think private enterprise could have solved the problems of these past years if it had been enlightened and wise?" The Minister had an answer and he gave it at once. "Private enterprise is not all bad," said Aneurin Bevan, "but it cannot solve the problems created by modern society. The reason is that most evils of the world, including ill health, are man made. They cannot be avoided unless society is organized to prevent them." He did not elaborate. There was no need. He had honestly stated his position as he saw it.

My next question was regarding the Health Service. Was it necessary to supply everything completely free? "It is generally accepted," explained the Minister,

"that a government has the responsibility of providing a pure water supply for all of its citizens. It has just as great a responsibility to provide health services for all the people."

Whether I was in accord with that statement was not important. My job was to get answers, not to give them. My next question was, "What about the terrific cost of providing all these free health services?"

The Minister thought for a moment and admitted that many were saying this system was too costly. "But," he added with considerable conviction, "We do not believe that the total cost for doctors, medicines, hospitals,—for everything is more than 20% higher than what the nation was spending before this National Health Service began." The Minister was referring to the unofficial report that it was now costing about \$1,200,000,000 in our money. He claims that this is only \$200,000,000 more than was formerly spent under private medicine.

Mr. Bevan was doing his best to help me understand all of the factors. So I remarked that some who favored the Scheme had told me it would have worked out much easier the first year if it had been introduced more gradually instead of all at once on July 5, 1948. He was well aware of this attitude, but he is not in accord with it.

"Some say that no nation should attempt to do what we have done so quickly. They say we should have done it more gradually, piece by piece, step by step. For example, they would have had us take hospitals first, then general practitioners and so on. But they forget that such a great social change cannot be done gradually. It must be done all at once on a day selected for the purpose." The Minister paused and I said, "You mean like D-Day, everything organized?"

"That is exactly right," he continued. "The D-Day method is essential to an invasion. So is it to the inauguration of a great change in society. The idea is that this day must serve as a catalytic agent, one to which everyone in the nation must react. Otherwise such a major change in society cannot be done. To do it gradually, piece by piece, step by step, would create many resistances and make the Minister subject to everyone else instead of having them subject to him. It is his responsibility to make the new system work, and he cannot do that if he is not master, if he does not have complete control. He cannot be master if it is done gradually, step by step."

While he was saying all of this, I was making my notes and wishing that more of our American politicians had the courage to be as honest and forthright in their replies.

At this point, someone came and told the Minister that he must go some other place. As we got up to go, I asked, "Do you think this Health Scheme of Great Britain will work in America?" Mr. Bevan replied, "The method we are using to provide health for the people will spread all over the world. In modern society, it is inevitable. America must come to it—Ta, Ta, Mr. McPherrin, come and see me again sometime."

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. J. L. Sanders, Greenville, S. C.

Publicity Secretary: Mrs. Kirby D. Shealy, Columbia, S. C.

HAWTHORNE CITES CONDITION OF SCHOOL DISTRICT NO. 17

Mark F. Hawthorne, superintendent of the Anderson City schools, spoke to members of the Anderson County Medical Auxiliary who met at the Calhoun Hotel Tuesday afternoon, Sept. 27 for a Dutch Luncheon; telling them primarily of the conditions of school district No. 17. He emphasized the need for more money, particularly in regard to establishing a fund for a lunch room. As one of the 300 largest school districts in the United States, continued Mr. Hawthorne, district No. 17 spends less money than any school of its size.

The theme of his address was "Men Should Be at Work."

Prior to the guest speaker's introduction by Mrs. S. Harry Ross, the invocation was given by Mrs. A. L. Smethers who also gave an original poem written about doctors and nurses.

Mrs. S. O. Pruitt, president, presided over the business at which time a number of interesting projects and programs were announced as forthcoming for the club year.

Luncheon was served in the private dining room of Calhoun Hotel at a long dining table decorated with three arrangements of dahlias, roses, and other mixed fall flowers.

Miss Sarah Haynie played "Irish Dance" and "Baby Stars" by James Farmer.

officers and committee chairmen were present and gave reports of the work being done. Of special interest was the report given by Mrs. H. L. Timmons of Columbia, chairman of the committee appointed to draw up rules for the handling of the newly established student nurse's loan fund.

Elected to serve on the nominating committee were Mrs. M. Nachman of Greenville, chairman, Mrs. E. Gordon Able of Newberry, and Mrs. P. M. Temples of Spartanburg.

After adjournment luncheon was served at one o'clock in the private dining room of the hotel. The tables had been beautifully decorated with fall fruits and foliage by the Greenville Medical Auxiliary. A corsage of yellow chrysanthemums, attractively wrapped favors and a gift from the president marked each place.

Special guests for the occasion were Mrs. W. P. Barton of Greenville, Dr. J. Decherd Guess of Greenville, chairman of the advisory council to the Auxiliary, and Mr. M. L. Meadors of Florence, director of public relations for the Medical Association and its counsel, also a member of the advisory council. Dr. Guess was the luncheon speaker. He brought greetings from the South Carolina Medical Association in behalf of its president, Dr. Roderick MacDonald of Rock Hill, and spoke on the project for the year, "Maternal Welfare." Mr. Meadors also spoke briefly.

THIRD DISTRICT AUXILIARY

The Woman's Auxiliary to the Third District Medical Society will hold its first meeting for the year November 1st in Newberry at the Community Hall in the Court House. The following are the officers and committee chairmen for 1949-50:

President, Mrs. E. Gordon Able	-----Newberry
Vice-Pres., Mrs. George Rosenberry	-----Abbeville
Secretary, Mrs. J. C. Scurry	-----Greenwood
Treasurer, Mrs. W. J. Holloway	-----Ware Shoals
Historian, Mrs. J. R. Power	-----Abbeville
Student Loan Fund, Mrs. J. W. Tate	-----Calhoun Falls
Jane Todd Crawford, Mrs. C. J. Scurry	-----Greenwood
Membership, Mrs. R. E. Livingston	-----Newberry
Publicity, Mrs. E. W. Tucker	-----Greenwood
Program, Mrs. M. J. Boggs	-----Abbeville
Public Relations, Mrs. T. F. Stanfield	-----Abbeville
Legislative, Mrs. T. F. Stanfield	-----Abbeville
Maternal Welfare, Mrs. J. W. Bell	-----Greenwood
Hygeia & Bulletin, Mrs. L. R. Kirkpatrick	-----Ware Shoals

Nurse Recruitment, Mrs. F. C. McLane	-----Ware Shoals
Doctors' Day, Mrs. Arthur Welling	-----Newberry
Arrangements, Mrs. W. S. Bishop	-----Greenwood

EXECUTIVE BOARD MEETING

The mid-year executive board meeting of the Woman's Auxiliary to the South Carolina Medical Association was held at the Hotel Otteray in Greenville at eleven o'clock on October 5. Mrs. J. L. Sanders of Greenville, president, presided.

The meeting was opened with the Auxiliary pledge, followed by greetings from the president. Thirty-five

STUDENT NURSE LOAN FUND

The Executive Board of the Woman's Auxiliary to the S. C. Medical Association in session Oct. 5th in Greenville completed the details and set up for immediate operation the "Jane Todd Crawford Student Loan Fund" for nurses with Mrs. Roderick MacDonald of Rock Hill as chairman.

While the problem of financial aid for student nurses is not new, its solution is becoming increasingly important. Lack of funds was the decisive factor for more than 25% of the students who were unable to register in one training school last year.

The following rules for governing the nurse loan fund were adopted at the meeting at Greenville:

1. It is the aim of the Jane Todd Crawford Nurse Loan Fund to assist as many girls as possible; therefore no large loans will be granted. Loans will not exceed \$300.00, payable at the rate of \$100.00 per year.
2. Scholarships shall be awarded only to girls who have completed high school and who have been accepted by an accredited school of nursing.
3. Loans shall be awarded on the basis of scholarship, character, and need.
4. Each girl borrowing from the Loan Fund shall give note for amount borrowed, such note being endorsed by men or women of sufficient financial responsibility to be satisfactory to Chairman of Loan Fund.
5. Money will be loaned without interest if repayment is begun on securing employment following graduation. One third of the total amount to be paid annually without interest, with the option

of paying the full amount. Interest at the rate of 5% will be charged on amount of unpaid loan at the end of three years.

6. The amount allotted to one girl for one year shall be paid in two installments; one at the beginning of the term and the other in mid-year, a separate note being given for each amount.

7. After filing application blank a personal inter-

view by the committee shall be required.

8. The application blank shall be filled and accompanied by three letters of recommendation as well as a personal letter sent to the Chairman of Loan Fund.

Application blanks will be available from the presidents of the County Auxiliaries and the Chairman of the Nurses Loan Fund.

ANNOUNCEMENT TO DOCTORS

THE LAURENS REST HOME

operating under the medical direction of TWO COMPETENT LICENSED MEDICAL DOCTORS—offers HELP AND INDIVIDUAL treatment to consent patients for ALCOHOLISM.

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Echinococcus Infection

Report of a Case in an Immigrant in South Carolina

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Charlottesville, Va.

and

ROBERT WILSON, JR., M.D.

Charleston, S. C.

Hydatid disease, or Echinococcus disease, is known to exist on all continents. Magath,¹ in a comprehensive review of the subject in 1939, stated that the first case in North America was reported in 1882. From 1882 until 1939 a total of 519 cases had been reported. He noted that most of the diagnoses were made in the larger medical centers. Swartwelder,² in a review of 15 cases in Louisiana, noted that these cases were diagnosed after 1932 and attributed this, in part, to an increasing knowledge of the disease among physicians. Ten of his cases were in native Americans who had not been out of the country. Magath,¹ in his report, noted that only 29 of the 519 cases were in native born Americans, and of these, some probably contracted the infection out of the continent. He further noted that the disease was found more commonly in immigrants from Iceland, Italy, Greece, Russia, and Great Britain and in the order named. The majority of his cases were reported from New York, Manitoba, California, Massachusetts, Pennsylvania, Illinois, Quebec, Missouri, and Minnesota in the order named. Case reports, in smaller series, are found from many other states and Canadian provinces.

Hydatid disease is caused by infestation with a tape worm, genus Echinococcus, which is a habitual parasite in the intestinal tract of dogs, jackals, and wolves. *Taenia Echinococcus granulosus* is the most common species. Man, when infected, is the intermediate host in the life cycle of the parasite. Development of the larva of *Taenia Echinococcus* in man produces a cyst, which may grow to an enormous size. No tissue in the body is immune to this infestation and the cysts may form in any organ. Seventy per cent, however, are found in the liver, with the lungs, peritoneal cavity, and pelvis being the next most common sites.

The disorder is usually brought to the patient's attention by symptoms due to the pressure of the

growing cyst. These symptoms will vary with the location and size of the growing cyst and the degree of impairment of normal functions that it produces. Relapsing urticaria and eosinophilia are two other commonly associated findings. Hydatid cyst is the most common cause of a calcified area in the liver and X-ray evidence of calcification of the liver is very suggestive of the disease.⁴

The diagnosis is most often made during surgery when the cyst is visualized. Occasionally hooklets of the parasite are found in the feces or sputum after the cyst ruptures into a hollow viscus. The finding of these hooklets in any body fluid is diagnostic. They may also be found in fluid aspirated from the cyst if this is done. However, if Echinococcus disease is suspected aspiration should not be done. In suspected cases an intradermal test, known as the Casoni test, and a complement fixation test may be used to confirm the diagnosis.

Echinococcus infestation is a serious disease with a mortality rate of approximately 13%. In an occasional case the parasite will spontaneously die and the cyst will calcify, but this is not to be expected. There is no treatment other than radical removal of the cyst by surgery if it is accessible. Surgical removal of the cyst carries the hazard of rupture with the contents of the cyst spilling on uninfected tissue. This can cause reinfection and the formation of secondary cysts.

J. G. F., a 46 year old white male and a native of Greece, was first admitted to Roper Hospital in September 1933 with an upper respiratory infection. An X-ray of his chest (Fig. 1 and 2) showed an area in the right lung, roughly over the middle and lower lobes, to be cloudy and without aeration. A double shadow noted in the base was thought to represent either movement of the diaphragm or a mass between the diaphragm and the pleura. The patient recovered from the immediate illness and left the hospital before



FIGURE 1
Sept. 25, 1933

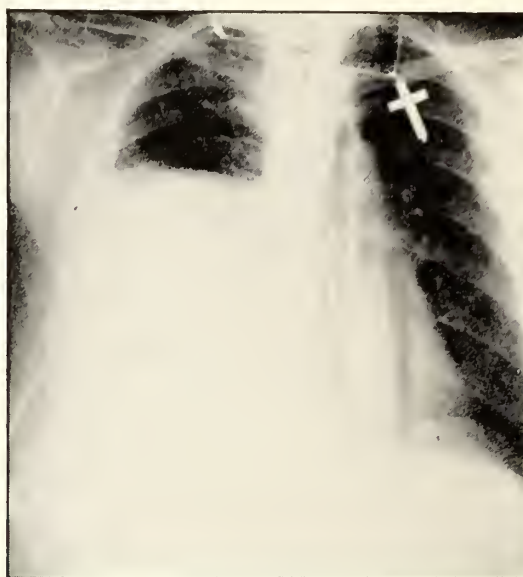


FIGURE 3
Dec. 25, 1938

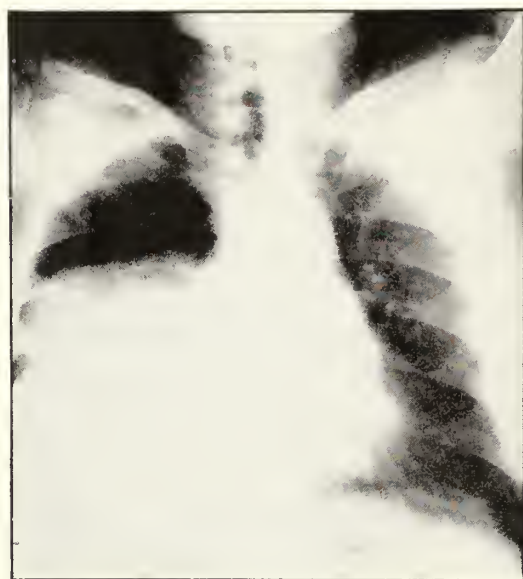


FIGURE 2
Sept. 28, 1933

the cause of his unusual X-ray findings was explained.

He was admitted for the second time on December 5, 1938 because of a cough and fever of two weeks duration. The cough was productive of a white watery phlegm; the history was negative for rust colored sputum or blood. The fever was higher in the afternoon.

Physical examination revealed a well developed and nourished patient. Respiratory movements were diminished on the right. Vocal fremitus was decreased and breath sounds diminished on the right, both anteriorly

and posteriorly, from the third rib down. This area was dull to percussion. Clinical findings and X-ray studies (Fig. 3) were compatible with right pleural effusion. The WBC was 18,600 with 86% polymorphonuclear cells and 14% lymphocytes. Type 4 pneumococcus was found in the sputum. Another X-ray of the chest reported the same mass on the right that was noted originally in 1933.

During the course of this illness the temperature continued to spike, ranging from 98.3 to 102.5. The patient complained of frequent chest pain. On December 16th a sub-diaphragmatic infection was suspected and a thoracentesis was done. Examination of the fluid aspirated showed the hooklets of *T. Echinococcus*. The diagnosis of Echinococcal cyst was then established.

After further examinations by X-ray it was concluded that the cyst was above the diaphragm. A double shadow persisted in the region of the diaphragm and the possibility of two cysts was considered.

Surgical exploration was done on January 6, 1939 and a cyst was found, its wall adherent to the pleura. It was successfully removed. On gross examination it was found to contain semipurulent fluid and a number of daughter cysts. During the operation the patient expectorated a fluid that resembled that found in the cyst. Recovery was uncomplicated. The temperature returned to normal and improved rapidly. On two occasions following the operation hooklets were found in the sputum. He was discharged on January 29th in good condition.

The patient was admitted for the third time on May 12, 1941 for the repair of a hernia. No clinical

or laboratory findings suggested infection with *T. Echinococcus*. The recovery was uneventful.

He was admitted for the fourth time on November 7, 1945 for the repair of a left recurrent inguinal hernia. Physical findings showed no change since the last admission. An X-ray of the chest showed a large mass, either supra or infra-diaphragmatic, in the right chest extending to the chostochondral junctions. The mediastinum was displaced to the left and a small mass was noted in the base of the left pleural cavity. One hooklet was found in the sputum.

The hernia was repaired on November 14th. His temperature became elevated to 100 degrees and he was given penicillin. His general condition became worse and he complained of chest pain. Recurrence or extension of the echinococcal cyst was suspected. Penicillin was discontinued and sulfadiazine was begun. There was no improvement and he continued to grow worse. A hemorrhagic rash appeared on the thorax, back, abdomen, and inner aspects of the thighs and arms. This rash was attributed to the sulfadiazine, which was discontinued. A mild hemoptysis occurred, but the rash cleared and began to improve. He was discharged on December 23rd much improved.

The patient was admitted for the fifth time on November 17, 1947. He complained of fever for the preceeding six days, high in the afternoons and normal in the mornings. He stated that he had had dyspnea since the thoracotomy in 1939. At the time of this admission he was taking sulfadiazine which had been prescribed at home.

Physical examination revealed a well developed and nourished patient of about 60 years of age, acutely ill. A hemorrhagic rash was present on the legs, arms, abdomen, and lumbar area. The pharynx was moderately injected. Respiratory movements were limited on the right and breath sounds and vocal fremitus were absent over this area. No rales were noted. The heart rhythm was irregular. The liver was markedly enlarged, extending to the umbilicus. There was no evidence of ascites. The blood pressure was 140/80.

The laboratory findings showed the RBC 4.13 million, Hemoglobin 11 grams, WBC 18,350, PMN 78%, Lymphs 20%, and monocytes 2%. The BUN was 17 mgm. per cent and the blood sulfadiazine level was 4.5 mgm. per cent. The urinalysis was not unusual except for three plus albumin. The electrocardiogram

showed auricular fibrillation and T wave changes in lead four suggestive of an anterior myocardial infarction.

The hospital course following this admission was not good. Auricular fibrillation continued and he was digitalized. Pyribenzamine was given to note its effect on the rash. Dyspnea continued and the patient became weaker. The temperature dropped from a daily range from 101 to 102 degrees to 99 degrees and remained there.

On the eighth hospital day his condition was grave. The pulse was 100 and regular and the blood pressure 150/60. No change was noted in the physical examination of the lungs, but the dyspnea continued. The possibility of echinococcus infection of the myocardium was considered.

On the afternoon of the eighth hospital day he rapidly became weaker and the blood pressure dropped to 92/50. He did not respond to any supportive drugs or measures and expired shortly thereafter.

No autopsy could be obtained.

SUMMARY

1. A case of *Echinococcus* disease occurring in an immigrant living in South Carolina is reported. The disease has not previously been reported in South Carolina so far as can be determined.
2. No attempt is made to review the literature with reference to diagnosis and treatment. This information is available in textbooks on medicine, surgery, and pathology.

REFERENCES

1. Magath, T. B.: Hydatid Disease (*Echinococcus*) in North America, Pennsylvania M. J., 44: 813, April 1941.
2. Swartzwelder, J. C.: *Echinococcus* Infection (Hydatid Disease) in Louisiana, New Orleans Med. and Surg. J., 99: 617, June 1947.
3. Gradwohl, R. B. H., Clinical Laboratory Methods and Diagnosis, ed. 3, St. Louis, The C. V. Mosby Company 1943, Vol. 2, 1856.
4. Heilbrun, N. and Klein, A. J.: Massive Calcification of the Liver, Am. J. of Roent. and Rad. Therapy 55: 189-192, Feb. 1946.

Recent Advances in Diagnosis and Treatment of Rheumatic Fever

WILLIAM WESTON, JR., M.D.
Columbia, S. C.

We recognize rheumatic fever as primarily a disease of childhood, however many cases go, or shall I say have gone, undiagnosed until adult life, yet the initial attack was during childhood. Rheumatic fever is one hundred times more common in childhood than is poliomyelitis.

Definition: Rheumatic fever is a systemic disease characterized by the involvement of several systems such as joints, skin, nervous system and particularly the heart.

Etiology: Numerous workers in this field have shown that the disease is usually preceded by an upper respiratory infection caused by the streptococcus haemolyticus A group. Those of you who have been working in this field must be impressed by the allergic manifestations of these individuals, that is they have previously had hay fever, bronchitis, urticaria, etc. So the streptococcus haemolyticus sets up an antigen to which the person reacts, thus producing the active symptoms and signs of rheumatic fever.

The studies of Wilson¹ in the genetic susceptibility in rheumatic fever have been clearly demonstrated and it follows the Mendelian laws of recession, that is, the more forebears one has with rheumatic fever the more likely is the sibling prone to this disease.

Symptoms and Signs: The epic approach to the major and minor manifestations of Jones² should be mentioned here:

Major Manifestations:

- (1) Carditis
- (2) Arthralgia, migrating joint arthritis
- (3) Chorea
- (4) Subcutaneous nodules
- (5) Recurrence of rheumatic fever

Minor Manifestations:

- (1) Fever
- (2) Abdominal pain
- (3) Precordial pain
- (4) Rashes
- (5) Epistaxis
- (6) Pulmonary findings
- (7) Laboratory findings

Jones states that if any one of the major manifestations plus one or more of the minor signs are present then the patient has rheumatic fever.

We have a goodly number who have joint pains, carditis, and chorea but the subcutaneous nodules are rare, and with us a serious sign. Most of our cases do

not develop carditis following the first attack of chorea, usually it is found after the second attack and practically always follows the third attack of chorea.

Rheumatic Fever is divided into four periods;

- (1) Onset (2 to 5 days)
- (2) Quiescent (1 to 3 weeks)
- (3) Activity (4 weeks to 3 months)
- (4) Convalescent (2 weeks to 6 months and eventual recovery or lethal exodus)

Some authors dogmatically state that chorea is rheumatic fever but I do not believe this is altogether true. Unless there is involvement of the heart or other signs associated with rheumatic fever I think one can well have St. Vitus dance or chorea without having rheumatic fever. Certainly if the case is followed through puberty and there are more than two attacks, in all probability the patient will develop definite signs of rheumatic carditis. Most cases will have more than one attack but if the patient is allowed to recover sufficiently, that is, given plenty of time and rest and free from excitement and emotional disturbances, then a complete recovery will be made and perhaps no further attacks will develop. The sedimentation is very important in this disease and when there is no elevation in the erythrocyte sedimentation rate the patient in all probability will not develop any heart disease, whereas if there is an increase in the sedimentation rate the patient will develop signs of rheumatic heart disturbances. I would like to quote the summary of Kagan and Mirmam³ in regards to chorea "Sydenham's chorea may be associated with rheumatic fever or it may be non rheumatic. Patients with non rheumatic chorea are no more subject to the sequeli of rheumatic fever than are other members of the population." I think you might conclude that patients in South Carolina who have Sydenham's chorea will have an excellent outlook provided they are given proper care. Some of the former treatments of chorea have fallen into disfavor such as fever therapy, either hot packs or an electric box, or by foreign protein such as injection of typhoid fever, also the ketogenic diet has not proved satisfactory but the use of sedation such as phenyl-ethyl-hydantoin (Nirvanol) or phenobarbital derivatives give the best results. The patient should be isolated and given the proper food even though it might have to be fed and of course the patient needs protection from injury, such as bed may be blanketed and restraint may be necessary at times. The electroencephalography and the electromyography are used to denote the extent of the disease and also the progress. The squeezogram described by Cohen and Dancis⁴ is a fairly simple apparatus.

(Presented at Annual Session, May, 1949, Myrtle Beach.)

Rheumatic fever clinics must be set up either on the community basis as we have recently seen in Memphis where Hughes⁵ has outlined and set up his clinic or as we have in South Carolina, there are three rheumatic fever Districts, namely; the mother clinic in Charleston under the capable head of Dr. Mylnor Beach, one in Greenville directed by Dr. Lonita Boggs and I am fortunate enough to be chief in the middle district which is located in Columbia. Certainly it was a forward step taken by the State Board of Health under the able direction of the crippled children's division, Dr. G. S. T. Peeples, when he organized the rheumatic fever clinics and in this way the problem in my mind is being well solved. A good pediatrician of North Carolina told me that they were not confronted with the problem of rheumatic fever but I am certain that this doctor is mistaken, for many years we did not think that it was a problem in South Carolina⁶ but now we know that there are many cases of rheumatic fever and we are finding them through the cooperation of the doctors throughout the state with our clinics.

Rheumatic fever is a medical, social, educational and economical problem. The New York Heart Association set up a grant which would take care of the indigent children within that territory. It was an idea for a pilot study so as to take care of these children at home after they have been dismissed from the hospital. "In a typical year 2,181 children under 14 years of age with heart disease were discharged from the hospitals of New York City. 66% of them were discharged in less than 30 days; another 19% after a stay of between 31 to 60 days. This total of 1,854 does not include those with simple rheumatic fever or chorea (St. Vitus dance)."⁷ Now most of these children needed prolonged bed rest, they needed medical

attention, they needed psychiatric guidance, they needed nursing care, they needed occupational therapy and this was done with most of these children and only a few of them went to convalescent homes. It was a carefully worked out plan under Dr. Martin Cherkasky who acted as captain of the team. If any laboratory work, x-ray or electrocardiograph studies were necessary then the ambulance was sent for the child and returned to the hospital for this type work, if other physicians were needed then they were called in for consultation. In other words it was a continuation of the treatment of the child in the home rather than in the hospital so that the patient-child relationship could remain. The home nursing care played an important part and the visiting nurse is the one really responsible for this part.

Many congenital lesions have rheumatic fever superimposed with involvement of the mitral and/or aortic valves and other valves occasionally. There are many cases of sickle cell anemia with carditis that subsequently develop rheumatic carditis.¹⁸

The sedimentation rate is emphasized as it will often indicate not only the activity but also the progress of the disease.

Our results with the electrocardiogram have not shown as many abnormal tracings as many investigators in this field have shown. Rosenberg¹⁴ found abnormal EKG changes in 63%, however Sokolow¹⁵ states that the electrocardiographic changes may be variable, intermittent and short lived. Most of the cardiologists have emphasized that prolonged PR interval which we rarely find, but Sokolow observes that a partial A-V block is the most common abnormality seen in rheumatic fever. Johnson¹⁶ inter-

DIFFERENTIAL DIAGNOSIS

Disease	Fever	W. B. C.	Agglut. Titer & Specific Blood	Pathology	Sed. Rate
Rheumatic Fever	+	+	—	Aschoff Bodies	+
Undulant Fever	+	+	+		—
Sickle Cell Anemia	(+) (—)	+	Sickling of RBC	Bone Marrow	(+) (—)
Rheumatoid Arthritis	(+) (—)	—	—	—	+
Septic Arthritis	+	+	—	(Purulent material from joint)	+
Luetic (Syph) Hydrarthrosis)	—	—	(Positive Serology)	Luetic lesions	—
Leukemia	(+) (—)	(+) (—)	Bone Marrow	(Repeated bloodsmears and bone marrow)	(+) (—)
Tuberculosis	+	—	—	Lesions in chest	+
Lupus Erythematosus	+	—	—	(Hematuria exposed areas)	—
		Leucopenia		(Ulcers in mouth)	
Poliomyelitis	+	—	—	(Muscle weakness Spinal fluid changes)	(+) (—)
Parasites	—	—	—	Stool exam. show ova	—
Lymphocytosis	+	+	(+ (Hetrophile) (—)		—
Dengue Fever	+	+	—		—

prets the broadening of the P wave and QRS interval as significant of cardiac disturbance in rheumatic fever.

Burford and Carson⁸ have given some beautiful demonstrations of retroarterial diodrast injection. This has been done by using the left common carotid artery and they conclude that it is a perfectly safe method and through this method "effective means of diagnosing questionable cases of patent ductus arteriosus, coarctation of the aorta, and aortic arch anomalies, and is useful in proving and disproving selected cases of aneurysms."

Cardiography has made rapid advances and progress lies ahead. We cannot well suggest cardiac surgery without mentioning Taussig and Blalock,⁹ and our late lamented Dr. Horace Smithy¹⁰ who was certainly a pioneer in this field.

Treatment: Diet has been stressed by some¹¹ in the treatment of rheumatic fever. Ross¹² points out that very few of the boys in the so called public schools of England have rheumatic fever. This he attributes to the large amount of beef and mutton in their diets; however, the incidence of rheumatic fever in adults in England is high and meats do not constitute an important element in their diet. He also notes that very few of the Britishers developed rheumatic fever in the first world war although they were in the trenches under the same conditions as the French and the Americans. The observation he attributes to the large amount of bully beef in the British diet. In addition to meat, eggs, and milk we recommend an abundant supply of Vitamin C, Vitamins K. and D. Duncan¹³ states that rheumatic fever does not exist in the Yukon where the people are huddled together in cabins and suffer with repeated attacks of streptococcus sore throats but do not have rheumatic fever due to the high incidence of meat in their diet.

Salicylates remain the drug of choice producing the most beneficial results in the acute case. Large amounts are advised. The patient tolerates grains 1 to 1½ per pound body weight well especially if aluminum hydroxide is added to prevent gastric distress.

Practically all of my patients both private and those in the clinic receive sulfadiazine from 0.5 to 2.0 grams per day (24 hours) usually divided into two doses. It is frequently reduced in the summer but not discontinued as this is apt to cause a drug sensitivity when it is renewed. We have had few recurrences, less than two percent. I give the sulfa drug for five years or through puberty. White blood counts, hemoglobin and sulfa levels are determined at intervals of two weeks to three months.

Some doctors are advising the use of penicillin at the onset of an acute infection, others use it continuously in the form of a troché (5,000 to 100,000

units) daily or twice a day as a preventive.¹⁷ We use penicillin injections before and after an operation or tooth extraction as a preventive with excellent results.

We have had in our rheumatic fever clinic:

Whites 111	Colored 76	Total Number 187
Rheumatic fever	White	Colored
111	58	53
Nonrheumatic		
55 (congenital 3)		
Doubtful		
21 (history)		

72 of our rheumatic fever cases (whites 37 and colored 37) have been placed on sulfadiazine and only 6 have been taken off, which has been due to age, only one to drug reaction, one by mistake and the others were doing so well we discontinued the drug.

The patient who shows heart failure in rheumatic fever is treated just like a patient who shows failure in any other heart disturbance and there are seven precautionary measures which I would like to mention that are needed to take care of these patients:

1. Rest. The patient should be in bed in a comfortable position. Here I am referring to a back rest or else in a rolling chair in the most comfortable position with the legs extended. Sometimes it is necessary to have a prop for the head so that during sleep when the head falls to one side he will not become orthopnoeic. If it is more comfortable for them to use the commode or toilet than to use a bed pan help them with this procedure and allow them to use it.
2. Oxygen.
3. Salt intake reduced to only that which is included in the diet, and no free salt added.
4. Liberal water intake. Allow the patient to drink as much water as he will and still remain comfortable.
5. Mercurial or saline as magnesium sulfate.
6. Digitalis. Here I would like to emphasize that a sufficient dose be given to digitalize the patient as soon as possible and then reduce the dose so that they can remain on a given amount.
7. Sedation: Many patients do not get sufficient rest. When it is observed that this is the case and other methods of sedation prove insufficient it is my experience that proper use of morphiates should be resorted to.

F. R. Colored Age 21 months.

History:

One of twins. Both children did well until two months ago (November 1947) when this child lost her appetite and had some fever. She received sulfonamides and penicillin by the local doctor in Ridge Springs but gradually became worse. She was ad-

mitted to the Columbia Hospital January 17, 1948 and died thirty minutes later of the same day. No examination was made previous to death but a post mortem examination was granted by the coroner.

Heart:

The heart valves which were beady in appearance and they were semi-translucent. There was some constriction of the valve leaflets and dilatation of the valves at the bases. This produced a rather marked mitral insufficiency. There was a marked left-sided dilatation and some hypertrophy of the ventricle. The right side of the heart showed no lesions.

The cause of death:

"Rheumatic fever; rheumatic valvulitis; mitral insufficiency; cardiac failure; ascites; hydrothorax; pulmonary congestion."

Summary: The recent advances in the diagnostic procedures of the heart have been mentioned, such as cardiography with diodrast which is especially beneficial in ruling out congenital lesions. The x-ray of the heart in anterior-posterior, lateral and right oblique is helpful. The fluoroscope is very useful in determining the size, shape, and position of the heart. The stethogram is suggested in order to denote the timing of the murmur, but we have not used it. The EKG is employed regularly, but has not yielded us the greater proportion of abnormalities a number of authors have found with rheumatic fever. Perhaps our cases are milder. The sedimentation rate is most useful, not only in the diagnosis but also in the prognosis of the disease.

The treatment of the disease has been briefly sketched with the use of salicylates in large quantities, then giving sulfonamides in the chronic stages to prevent recurrent attacks. Penicillin as a preventive is mentioned, also foods rich in protein and vitamins are recommended.

Conclusions: Rheumatic fever is a common disease among children and even in South Carolina.

The diagnosis with us depends mainly on the history and examination findings rather than on the laboratory technique.

The disease is just as prevalent among whites as among negroes, but in the latter the heart is more seriously affected.

Rheumatic nodules have been an ominous sign in our clinic.

A high protein and vitamin diet is recommended.

Sulfonamides have been used successfully as a preventive.

REFERENCES

1. Wilson, May G.: Rheumatic Fever, New York, The Commonwealth, 1940.
2. Jones, T. D. and Bland, E. F.: Clinical Significance of Chorea as a Manifestation of Rheumatic Fever, J.A.M.A. 105:571, August 24, 1935.
3. Kagen, B. M. and Mirman, B.: Sydenham's Chorea, J. of Ped., Vol. 31, September 1947, Page 322-331.
4. Cohen, Julius J. and Dancis, Joseph: The Squeezogram: An Objective Method for Recording The Course of Chorea. J. of Ped. Vol. 33 No. 5, November 1948, Page 564.
5. Hughes, James T.: The Child, Vol. 13, No. 9, March 1949, Page 137.
6. Beach, M. W., and Ravenel, B. O.: Rheumatic Fever, J. South Carolina M. A. 40:199, October 1944.
7. Rheumatic Fever: Pharmacal Advance, No. 181, March 1949.
8. Burford, Thomas H. and Carson, Merl J.: Visualization of the Aorta and Its Branches By Retroarterial Diodrast Injection., J. of Ped. Vol. 33, No. 6, December 1948.
9. Blalock, A. and Taussig, H. B.: The Surgical Treatment of Malformations of the Heart in Which There Is Pulmonary Stenosis or Pulmonary Atresia, J. A. M. A., 128:189-202, May 19, 1945.
10. Smithy, Horace G.: The Control of Arrhythmias Occuring During Operations upon the Valves of the Heart: Experimental and Clinical Observations, The Southern Surgeon, Vol. XIV No. 9, Sept. 1948, p. 611-618.
11. Weston, Jr., William: Rheumatic Fever in Childhood, J. Amer. Med. Assoc. Vol. 137, No. 8, June 1948, p. 675-682.
12. Ross, Alfred Rosshamm: Pharmacal Advance, March 1949, p. 6.
13. Duncan, A. M.: Lancet 6486:919-921, 1947.
14. Rosenberg, D. H.: New England J. Med. 234:148, 1946.
15. Sokolow, M.: Am. J. Med. 5:365, 1948.
16. Johnson, J. A.: Doctor's Manual for the Diagnosis of Rheumatic Fever, Rheumatic Fever Control Committee, Wayne County Medical Society, 1948.
17. Maliner, Martin M. and Amsterdam, Sol Darrell.: Oral Penicillin in the Prophylaxis of Recurrent Rheumatic Fever, Jol. of Ped. Vol. 31, No. 6, Dec. 1947, p. 658-661.
18. Ohrenstein, Irving Robert: Incidence of Sickle Cell Anemia with Rheumatic Heart Disease, J. of Ped. Vol. 33, No. 2, August 1948, p. 186-189.

Prolapse of Meckel's Diverticulum With Intussusception

REPORT OF A CASE

ARTHUR J. KATZBERG, M. D.

Newberry, S. C.

At the fourth week after conception the yolk sac gives the appearance of a pear shaped sac and opens into the digestive tube by a long narrow tube called the Vitelline or Omphalomesenteric Duct. As a rule the duct undergoes complete atrophy and obliteration during the seventh week. In about 3% of the cases its proximal part remains forming a diverticulum known as Meckel's diverticulum. Various other abnormalities of this embryonic structure may be found at birth or later; a fibrous band, a small fecal fistula at the umbilicus, or a complete intestinal tube two or three inches long, patent and protruding thru the umbilicus. This last being by far the least common and the most serious. These abnormalities of the Vitelline duct are found about three feet above the ileocolic junction.

The patient, a male infant two months of age, was a premature born at an estimated seven and a half months of gestation. The labor was normal, easy and of short duration for a primipara. It was necessary to give the mother progesterone from the second month until the sixth month because of recurrent symptoms of threatening, after this time there were no danger signs until premature labor started with rupture of the membranes. The infant was born apneic and stimulants as well as artificial respiration and oxygen were given over a period of one and one half hours before normal breathing was noted. The mother was given little premedication for analgesia and amnesia and it was felt that prematurity was the cause of the above symptoms. The birth weight was four pounds and eleven ounces. The infant was immediately placed in an incubator and was carefully watched. Examination at this time was unrevealing except for a rather thick umbilical cord, measuring one and one half inches in diameter. Under supportive treatment the progress of the baby was excellent.

As the cord dried it was noticed that a globular mass about the size of a walnut was present at the umbilicus and small amounts of gas and fecal matter escaped at intervals. When the cord had completely dried it was found that the mass was intestinal, the skin was adherent at the base, the mass was two inches long and was not reducible.

Perhaps of some interest was the hypospadias found in the father and the history of other congenital anomalies in his family. There was no history of congenital defects on the maternal side. This was the first pregnancy of a six year married life.

It was decided to carry the patient along until

adequate weight gain would make surgery more favorable. By means of a non necrotizing ligature and pressure dressings we were able to keep the amount of fecal matter extruded down to a minimum. The prolapse and the skin were kept in excellent condition and the patient showed satisfactory weight gain and improvement. The weight at two months was seven and a half pounds, a gain of almost three pounds. Careful examination at this time did not reveal any other abnormalities.

The parents reported that when the child had a bowel movement he would cry out as though he was in great pain, but that soon after he was quiet. One night shortly after a bowel movement the father decided to dress the prolapse, he noticed a large sausage-like mass worming its way through the opening. The mass was cherry red, tubular in shape and about eight inches long. I examined the patient almost immediately and found about eight inches of ileum presenting as an intussusceptum with the prolapse as the intussusciptum. How long this had been present was difficult to ascertain, but it could not have been long. Reduction was attempted at once and was not successful. The child was taken to the hospital after a small dose of Demerol was given and at the hospital reduction was again tried. Reduction not being successful immediate preparation for surgery was made. Under Demerol and local anesthesia with 1% Novocaine a laparotomy was performed. Drop ether was used as necessary for greater relaxation.

Through an elliptical transverse incision the umbilicus and the prolapse were excised and the peritoneal cavity entered. The tight band of the umbilicus was incised and the tissues examined. It was found that contrary to the usual situation the distal ileum was the intussusceptum. The proximal ileum was obstructed and distended. The intussusception was easily reduced in the usual manner, the prolapse was clamped transverse to the ileum, excised and the stump was sutured in a transverse manner using the smallest size atraumatic intestinal suture available. This was reinforced with interrupted mattress sutures. The intestine was examined carefully and watched. Gas passed readily into the distal ileum, peristalsis was active and circulation seemed normal. The gut was returned to the abdominal cavity without too much difficulty and a repair of the umbilical hernia was done.

The immediate postoperative condition was excellent. Treatment schedule set up was; continuous

suction, 300cc lactate Ringers solution subcutaneously daily, Penicillin 50,000 units every three hours, along with 125 mgm. Streptomycin, nothing by mouth and repeated small blood transfusions. Water was started on the fourth postoperative day—emesis followed almost immediately. All further attempts to feed the child were followed by distention and vomiting. The temperature remained normal until the seventh day when it began to climb in spite of medication. On the ninth day the patient expired.

Autopsy revealed a well healed abdominal scar. The incision was opened and a brownish purulent

material of thick consistency and foul but not fecal odor was found. Examination of the intestine showed the suture line of the diverticulum to be well healed, there were numerous small areas of necrosis distal to the site of the diverticulum, a number of which had pin point perforations. The mesentery nourishing these areas had multiple areas of thrombophlebitis. No further examination was done and no microscopic studies were made.

An interesting case is herewith reported, criticisms and suggestions are welcomed for future reference.

The Public Health Problems of Hookworm Disease in South Carolina

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History is filled with descriptions of plagues and great epidemics of disease and their effect upon civilization through the ages but the hazard of hookworm disease is not included in this category. Since it is not a spectacular condition but rather an insidious, undermining disease which causes its havoc without the victim fully realizing he is sick, the people are not aroused to defense against the malady. It is a condition which cannot be coped with individually but must be attacked on all sides with all the forces at the command of the people. Thus, it is obviously, a public health problem. The great importance in appreciating the dangers of the disease is full realization of the significance of its effect upon the mental, moral, and economic life of the people.

The hookworm, which wrought so much misery and poverty, has served its purpose. It has been the means by which public health work in the South has advanced to the point where it is, now, considered superior to the public health work done in any other part of the nation.

In the field of Preventive medicine, hookworm disease stands out, supreme as the one disease which has contributed most to the advancement of public health in South Carolina. Up to 1910, when the Rockefeller Foundation became interested in the eradication of hookworm in the south, our State Board of Health had never done any progressive work but was more or less, a passive organization which functioned only when it was called upon.

There seems to be a widespread belief among many public health officials, practicing physicians, and layman that hookworm disease has been so reduced by the control campaigns in the southern part of the United States, that it is no longer of any importance

as a public health problem. There is no doubt that the extensive treatment campaigns inaugurated by the Rockefeller Sanitary Commission followed by the development of programs for rural sanitation by the various state boards of health have greatly reduced the hookworm infestation over wide areas throughout the South. In fact, statistics from surveys in the past several years show marked reduction in both incidence and intensity. However, resurveys, also, show that there are still present areas of heavy infestation and clinical hookworm disease.

It is largely a disease of the rural population, where economic conditions of the poorer classes is low, as in the large rural sections of the southern states, but is not very prevalent in the cities or towns.

In South Carolina, the nature of the soil has a definite effect on the distribution, for at present, the greater portion of the infestation is below the fall-line which divides the state into two portions, according to the type of soil, namely, the eastern and western divisions. This line of demarcation cuts through the upper portions of Aiken, Lexington, Richland, Kershaw, and Chesterfield counties and illustrates the soil areas of the state. The eastern part of the state comprises more than one-half of the total area of South Carolina, within which 57% of the population of the state resides, and the soil is composed of sand or sandy loam, the sand being distributed, homogeneously, throughout the area. Soil of this type is most favorable for the development of hookworm larvae. Above the fall-line, the closely packed clay soil and the better drainage tends to limit the degree of infestation, for this type of soil is not favorable for the development of hookworm larvae.

In all sections, hookworm is a rural, rather than an urban disease, and the occupation of the individual, plays an important part in his chances for infection.

(This was the thesis receiving first prize from the theses submitted by the Senior Class of the Medical College of S. C. 1948)

One must remember in carrying out a worm-removal process in an individual, to always treat the anemia. Payne and Payne and others have shown conclusively that hemoglobin recovery following worm expulsion without iron therapy is a long drawn-out process. This is especially true when dietaries and iron are deficient. On the other hand, although iron administered alone produces rapid improvement in the blood picture, the gains are not sustained unless the worms are removed. Many state boards of health treat the anemia with iron preparations and, also, deworming processes are instituted; the time of removal of the worms depending on the condition of the patient. Educational efforts are made, thereafter, to improve the dietary so that greater iron intake in food is provided, especially in growing children in whom the concurrence of hookworm anemia and nutritional anemia is most marked.

Another most important factor in the incidence and intensity of hookworm infestation is the race factor. The white and brown races are more susceptible to the parasite than the negro races, whose members are often immune or act as carriers. The statewide survey of 1934-1935 showed an incidence of 7% among the negro race as compared to an incidence of 24.8% for white persons in the same areas. In addition, the degree of intensity of infestation in the negro was practically one-half the intensity found in the white persons in the same areas. The explanation of this important and interesting finding is definitely unknown to the many investigators of the hookworm problem, and should be investigated further.

In spite of decrease in incidence and intensity of hookworm infection, nevertheless, hookworm disease remains a source of physical disability and economic handicap in certain parts of the state with considerable amounts of time and money being spent annually by state and local health agencies, in its reduction.

Extensive surveys through the hookworm counties have clearly brought out that hookworm disease is resulting in considerable monetary loss to the school tax funds because of its inhibitory effect in the work of the classrooms. In a survey in Colleton County, Brabham found that failures in school work were four times higher in those infected with hookworm, than those in the negative group. Every backward child is a financial burden of the community over and above the average brighter child. Here, in hookworm disease, we have a factor which is costing our communities easily preventable financial loss in these times of threatening inflation. It has been estimated that the financial loss of hookworm disease to the schools is about thirty percent.

Expressed in the language of administrators, hookworm disease is more common among the backward school children who represent a proportionately higher average per capita expense to the schools than among the brighter pupils; and since mental retarda-

tion is a well-established feature of pronounced hookworm infection, it follows that we can save considerable money in our school budget and make our funds go further if we eliminate this menace from our school children.

In summarizing the preventive aspects of this subject, it may be said that although sanitation, treatment, and education remains the familiar armamentarium of the hookworm fighter, their application is now ordered and refined as never before by discrimination between hookworm disease and subclinical hookworm infection, by differentiating between the anemia due to hookworm and those due to other causes, and by the recognition of the family rather than the individual as the unit of investigation and control. The relation of diet to hookworm infection and its prevention is already known to be important; present knowledge suggests that it may become more so in the future.

The data presented show the incidence, distribution, and intensity of infestation with hookworm in South Carolina. At the present time, the condition constitutes a major public health problem in the state, especially the eastern division, and certainly warrants serious consideration on the part of the official health agencies, educational authorities, the medical profession, and other agencies interested in human welfare.

This area is, at present, the one in most need of a systematic program of control by the official health agencies in cooperation with the medical profession. Any program of control of hookworm should entertain mainly three objectives, namely, rid the patient of the parasite, teach him a proper method of sewage disposal, and educate him to wear shoes. Eradication of the disease is largely a matter of education.

The control measures against hookworm should be continuous and intensified by the state and local health departments with emphasis upon satisfactory methods of excreta disposal. If the state would provide sufficient funds and technical assistance to continue a program of hookworm control through the local health agencies in cooperation with the practitioners or medicine, it would be possible to bring about a further reduction in the prevalence, distribution, and intensity of hookworm infestation in the population to a point where hookworm disease would no longer be a significant public health problem.

From the available information on the present status of hookworm disease in South Carolina, it is possible to draw some general conclusions. In the first place, there has been remarkable progress in the organization of county health units and the development of rural sanitation as compared to the situation as found by the Rockefeller Sanitary Commission in 1910-1914. This has been shown to have greatly reduced both the incidence and intensity of hookworm infestation and the prevalence of hookworm disease. In spite of this progress in rural sanitation, it is well-known that con-

ditions are still far from satisfactory and a great deal still remains to be done. There are still areas of considerable size that are practically untouched by the sanitary program. Wherever, in such cases, the soil and climatic conditions are favorable for the development of hookworm larvae, the disease is still prevalent. This suggests that no let up can safely be made in the extension of rural sanitation and its conservation where a program has been carried through.

There are certain areas of high incidence of hookworm in South Carolina, where on account of the economic status of the population, it would be necessary to depend on treatment in great measure to improve the health of the individual. Under these conditions, treatment could be used as a stimulus to arouse interest in this problem and to obtain the co-operation of the people. It is likely that where this is done permanent measures could be eventually instituted, as treatment should be considered as an emergency measure and should not be employed as the permanent control measure or as a substitute for adequate excreta disposal.

This study revealed that hookworm disease is much more prevalent in the white man than in the colored

race. Heavy infestations with hookworms are common in the white race but rare in the colored race. It also appears that hookworm disease is more prevalent in half breeds and mulattoes than in the pure negro.

The demonstration of a high proportion of ancylostoma infections in men returning from the pacific may be of concern to the public health authorities in this country in view of the possibility of the introduction and establishment of this parasite, especially in the southern states where the soil, climate, and rainfall are very favorable for the development of hookworm larvae.

Hookworm disease is an entity of which the causative parasites and life cycles are known. There are efficacious drugs for its treatment. Its prevention is mainly a campaign of education and prophylaxis. With these facts in mind, there are hopes that within a few generations, hence, it will be eradicated from our midst.

I have made no effort to discuss the pathology, epidemiology, or any treatment, in detail, of hookworm disease in South Carolina but have tried to confine my discussion to the problem as a public health one.

To our readers, our advertisers, our friends

We Say

A Joyous Christmas Season

and

A Happy New Year

**TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION
1949**

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of the State of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

The Journal of the South Carolina Medical Association

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Florence, S. C.

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THOUGHTS FOR THE NEW YEAR

What better time than now, as the old year draws to its close, to sit alone with our thoughts, reviewing those things behind and planning for the things to come. What better time to take an inventory of what we are and to map our course for the days ahead.

With this mood upon us, we present five New Year resolutions for consideration.

1. *I will keep myself informed as to what is new and what is best in the science of medicine.*

We never fail to marvel at the progress which has been made in our own experience. The textbooks which we studied in medical school a quarter of a century ago are more out of date today than is the Model T Ford. To practice medicine at the present time without using synthetic vitamins, liver extract, plasma, the sulfonamides, and antibiotic agents would be to label one's self completely antequated and yet these are but a few of the preparations which have been given to the man of medicine in the past twenty-five years. Who can foretell what the next quarter of a century has to offer?

If a physician is to keep abreast of this progress, if he is to know what is new and what is best in the field of medicine, he must devote a definite portion of his day to study, to the reading of journals, to attendance upon medical meetings. Only in this way may he lay claim to the title, "man of science."

2. *I will endeavor to treat my patient as I would want to be treated, were I the patient and he the physician.*

It is difficult for a physician to put himself into the place of the patient sitting in his office. It is true that when a physician becomes sick he becomes a patient, but he is afforded professional and financial attention and courtesies which are unknown to the man in the street. He may suffer the same physical aches and discomforts as does his non-medical friend, but otherwise and naturally so—he is a privileged character.

Through conversation and observation we may draw certain conclusions, however, and here is what

we believe the average patient would say to his physician if he had the opportunity; "I want my physician to give me an early appointment, when I call him. If I need him at night, I want him to come. When I appear at his office at a given hour I want him to see me without a long wait. His time is valuable, but so is mine—and I would that he kept that in mind. I want him to take a personal interest in my condition, and to devote as much of his time and talent as is necessary to find out my trouble. I want a scientific appraisal not a snap diagnosis. I want to be told the truth, and to be told in terms which I can understand and not in sixty-four dollar medical terms. If he does not find my trouble, I want my physician to say so and to advise me as to where to go for further study. If I need an operation I want him to refer me to that surgeon whom he would trust with a member of his own family. For all of this, I expect to be charged a reasonable fee. I do not want my physician to work for me without just compensation, neither do I want him to become rich at my expense."

3. *I will assume my full responsibility in the life of my community.*

How easy it is for the physician, busy with his daily task, to forget that, man of medicine though he may be, he is also a citizen of his community. How easy to forget that along with privileges citizenship brings responsibilities.

A true citizen is not content to pay his taxes and feel that his work is done. He bends his efforts toward securing better schools for his community, better health conditions, better housing, better recreational facilities for the boys and girls, better government, better business opportunities. He wants to make his community a place in which he and his friends can be proud to live and to rear their families, a place in which every member of the community shall have the privilege of living the wholesome life.

Who is better qualified than the physician to assume a place of leadership in such community enterprise? His education, his experience in dealing with others, his knowledge of human nature, his medical tradition of service—all equip him admirably for the task.

4. *I will support actively the work of my church.*

"The greatest need in the world today is a spiritual rebirth of its people." Not only does this message come to us from ministers of the church but from leaders in government, in business, and in military affairs.

Communism, Godless and materialistic, is spreading its tentacles to the farthest corners of the earth. It can never be overcome by guns and atom bombs for it is an ideology, a belief, a way of thinking. It can only be overthrown by a stronger spiritual force, and that force is Christianity with its belief in the fatherhood of God and the brotherhood of man.

The church, frail though it may be in some ways because of human weakness, is still the great militant force through which a final victory over Communism may be won. To win the struggle, the church must have the enthusiastic support of every one of its members.

5. *I will live my personal life so as to bring honor to my profession.*

It has been our privilege to know intimately certain men whom we would call great physicians. Their names may not be mentioned on the pages of history, but they were great in what they were and in the impress which they made upon those whose lives they touched.

These men were skilled in the art of medicine—but they were far more than that. They were men of character. They were leaders in their communities. They were men who considered the needs of others more than they did their own comforts. They were men who loved their fellow men. They were humble men. They were men of deep religious convictions who strove to walk in the footsteps of the Great Physician.

These were men who were a real honor to our profession and we would do well to follow in their train.

CY O'DRISCOLL

At the recent Alumni Post-Graduate Seminar in Charleston, former students and friends of Dr. W. Cyril O'Driscoll presented him with an automobile and with an additional sum of money with which to take a vacation. The gifts were but a token of the love and esteem for Dr. O'Driscoll which prevails over the entire state of South Carolina.

We take pleasure in publishing the following letter from Dr. O'Driscoll in which, in his sincere and modest way, he expresses his appreciation for what was done.

My dear Dr. Price,

Because I wish to reach as many of the physicians of South Carolina as possible, and because your magazine is the best organ for that purpose, I am entreating you for space in which to publish this.

The physicians of South Carolina, my confreres and younger brothers, and foster sons, recently presented me with a beautiful, four-door, de lux, Chevrolet sedan, and a vacation purse. This kind act came from the workings of their good hearts and not from my merits.

I am ashamed and afraid, ashamed because I do not merit their generosity, and afraid because I am unable to show the extent of my gratitude. I would like everyone to feel how I so deeply appreciate it.

Because everyone might not read this, and because I wish everyone to know my sentiments, please those who read it, tell as many as you can.

I thank you; God bless you and yours,

Sincerely,

W. Cyril O'Driscoll

ANNUAL ASSEMBLY SOUTH CAROLINA ACADEMY OF GENERAL PRACTICE

The first annual assembly of the South Carolina Chapter of the American Academy of General Practice was held at the Columbia Hotel October 14th. General practitioners from all areas of the state were present.

The meeting started with a business session conducted by Dr. H. F. Hall, the president of the South Carolina Chapter. This was followed by a talk by Dr. E. C. Texter of Detroit, Michigan. Dr. Texter is president of the American Academy of General Practice, and he indeed honored the South Carolina Chapter by being present at their first annual assembly. He gave a review of the activities of the American Academy from its inception right up to its present membership of 12,000 and 43 chartered state chapters.

At the luncheon Dr. Frank Owens welcomed everyone to the meeting and to Columbia. After the luncheon Dr. W. L. "Buck" Pressly gave a short talk in which he emphasized the importance of the General Practitioner and how the trend is swinging back from too much specialization to more general practice.

The afternoon session opened with a talk by Dr. W. R. Tuten, the President-elect of the South Carolina Medical Association, on "What Can the General Practitioner Do To Combat the Trend of Socialized Medicine." Following this was a talk on "Endometriosis" by Dr. A. F. Burnside, our so well-liked Columbia surgeon.

Dr. Paul B. Beeson, the Professor of Medicine at Emory, gave the final paper of the afternoon. It was "A Consideration of General Supportive Measures in the Care of Acutely Ill Patients."

There was a delightful tea given for the ladies during the afternoon at the home of Mrs. R. L. Sanders.

In the evening there were refreshments followed by a banquet. After the banquet Dr. Tom Pitts enter-

tained everyone with numerous anecdotes of his days of general practice in the "hills and valleys of Saluda County." Following the banquet a dance was held.

The officers of the South Carolina Chapter of the American Academy of General Practice are: Dr. H. F. Hall, President; Dr. F. C. Owens, Vice-president; Dr. H. W. Mead, Secretary-Treasurer. The second annual assembly of the South Carolina Chapter will be held in Columbia next year. The next business session will be in Myrtle Beach at the time of the meeting of the South Carolina Medical Association.

Report on the Second National Conference on Physicians and Schools, Highland Park, Illinois, October 13-15, 1949.

Purposes of the Conference:

1. To evaluate progress made in the development of school health services since the 1947 Conference on Physicians and Schools;

2. To agree on methods of working together to improve and extend school health services at the state and local level;

3. To stimulate joint action of medical, public health and educational interests at the state and local level leading to the development of sound school health services.

The meeting was divided into four sections:

- Section I The Family Physician and School Health Services
- Section II The School Physician and School Health Services.
- Section III Interrelationships of Departments of Education, Departments of Health and Medical Societies in the School Health Services
- Section IV Implementing School Health Services at the State and Local Level.

Dr. W. W. Bauer gave us a most interesting talk regarding the conditions in Germany at the present time. He concluded that neither the teacher nor the children could understand the word "democracy." It is going to be a most difficult task to reorient and re-educate the children into a democratic life. The whole group seemed to be dependent on a hero worship.

Dr. Andrew C. Ivey, Vice-President in charge of Professional Schools, University of Illinois, gave us a most instructive address Friday evening, October 14, 1949, emphasizing the coordination and cooperation of the leadership of the doctors in various groups connected with the schools.

My conclusions are:

1. The school physician^o is an essential part of the school program in building for the future.

2. Close cooperation between school physician and the family physician so that there shall be no mis-

^oIf the medical group does not take the leadership, then another group will and the doctor will be under their direction rather than under his own direction.

understanding.

3. There should be pre-medical training such as family life, sex training, etc.

4. Pediatrics should lay greater emphasis on well children in normal development.

5. Orientation of school health. Small local groups unite and formulate plans in their community and work up to state level.

6. Implement the work as a group—that is the hub."

Administrator

Health Dept. and Nurses

Doctors

Under this head have health nurses and doctors in order to further the program carrying out the idea of improved health. Service through community (local) and state level and vice-versa.

7. Have a minimum of four examinations during school life—that is one every three years. New York has one annually. Pennsylvania has one every two years.

William Weston, Jr., M. D.

Official Delegate

South Carolina Medical Association

SOUTHEASTERN ALLERGY ASSOCIATION BULLETIN

September 19, 1949

The fifth annual meeting of the S. A. A. will be held at the Columbia Hotel, Columbia, S. C., on Saturday and Sunday, Feb. 11 and 12, 1950.

Guest speakers will be Dr. Jonathan Forman, president of the American College of Allergists and Dr. Theodore Squire, president-elect of the American Academy of Allergy.

In view of the popularity of panel discussions, there will again be two, one on "Pediatric Allergy" with Dr. Lewis Hoppe of Atlanta as coordinator, and the other on "Office Procedure" with Dr. Warrick Thomas of Richmond as coordinator.

There will be an informal luncheon on Saturday noon. The banquet will be held Saturday night, followed by a dance. Both will be at the Columbia Hotel.

All physicians interested in allergy are invited to attend.

SOUTH CAROLINA STATE BOARD OF HEALTH DIVISION OF CANCER CONTROL

Any physician who has a patient he thinks has cancer and is unable to pay for treatment may make application for the patient's admission to one of the state-aid cancer clinics. State-aid in the treatment of persons suffering from Cancer is obtained in the following way:

1. The attending physician must make application on behalf of the patient on forms furnished by the State Board of Health. These application forms are to be made in triplicate and can be obtained from

the County Health Departments or from the Division of Cancer Control, State Board of Health.

- (A) The physician filling out the blank should endeavor to supply as many details as practicable relative to the patient's condition. If the space on the form is insufficient, the additional information may be attached to the form.
 - (B) The physician should specify the clinic to which he wishes the patient referred, otherwise, the patient will be referred to the nearest clinic.
2. The application, in triplicate, is sent by the physician to the County Health Department of the county in which the patient resides. The County Health Department, as the State Health Department's representative, will refer the application to the Department of Public Welfare for additional data required to complete the application. The County Health Department sends the application

to the Division of Cancer Control for approval.

3. When the completed application is received and approved by the Division of Cancer Control, State Board of Health, the patient is given an appointment at the clinic specified by the referring physician. An authorization for his acceptance at the clinic, with a copy of the application, is sent to the Director of the Clinic, as it is necessary for the clinic to have this authorization before the patient can be accepted. *As the members of the staff give their professional services free of charge, they reserve the right to refuse to accept any patient whom they consider able to pay for services.* An acknowledgment is sent to the referring physician stating when his patient has been instructed to report to the clinic.
4. The patient should not go to the clinic until he has been notified by the Division of Cancer Control, State Board of Health, *when and where* to report for diagnosis and treatment.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

BLUE SHIELD CONTRACTS

As this is written contracts of physicians with the South Carolina Medical Care Plan are coming in slowly. By the time it appears in print it is hoped that the requisite number will have been received.

As has been stated in these columns several times previously, under the Enabling Act at least 50% of the duly licensed doctors of medicine in South Carolina must sign the contracts and thereby qualify as participating physicians with the Plan before it can begin to operate. During the month of October there were mailed to every doctor licensed in the State, whether or not a member of the South Carolina Medical Association, a contract form for execution by him, and a fee schedule, together with a letter requesting him to sign and return the contract to Dr. W. Wyman King, Chairman of the Committee on Physician Enrollment, Batesburg. An envelope addressed to Dr. King was also enclosed.

There are approximately 1400 licensed doctors of medicine in South Carolina and therefore approximately 700 signed contracts must be procured. It would be most unfortunate if there should be any undue delay in securing the requisite number of contracts. The idea that we might fail to get the necessary number has not been seriously considered, but the speed with which it is accomplished is of the greatest importance.

No particular effort has been made to publicize the Plan for the reason that the date of beginning its opera-

tion is indefinite. The people generally know, however, that the Plan is in the process of formation. The question is recurring with greater frequency when such insurance against the cost of professional care will become available, and it has been the purpose and the plan of the Board of Directors to put it into effect by January 1, 1950 if possible. Any physician who has not signed the contract and returned it to Dr. King by the time this appears is urged to give the matter his immediate attention and send in the contract.

Of course, some objections have been heard. One of the questions most frequently asked with respect to the Plan is this: Why are only surgical and obstetrical services to be paid for, and why has there been no provision for the payment of the general practitioner or other physician for straight medical care? The answer, on the basis of the experience of older plans now successfully operating and the experience of commercial insurance companies in this field, is that any attempt to insure against the costs of medical treatment generally in the home or in the physician's office is extremely hazardous. In many instances the existence of a need for such services is determined only by the patient's statements. The right to benefits is too easily abused to make it practicable to cover all types of medical care.

The Board considered fully the advisability of including medical care in the hospital but decided against this chiefly because it was thought the Plan should proceed slowly and take no risks of running into financial trouble in the beginning. We must



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*Werner, A. A.: The Climacteric in Women and Men, Postgrad. Med. 4:102 (Aug.) 1948.



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RESEARCH IN THE SERVICE OF MEDICINE

SEARLE

crawl before we walk.

Some questions have been asked—not many—about certain of the fees in the schedule. It would be strange indeed if the fees for a list of services of the length of this fee schedule and covering the wide scope of services that it does, should be entirely satisfactory to every member of a group of more than 1100. In the main, the schedule appears to be entirely satisfactory to the majority of the physicians. It was adopted by the House of Delegates without a dissenting vote. It follows closely the fee schedule of the Plan in North Carolina, and in more than one instance we have heard the comment by some physicians that certain of the fees are better than amounts now being charged by them for the services in question.

Finally, it should be borne in mind that the Plan is not designed and organized primarily for the direct benefit of the individual physician. It is designed for the purpose of enabling people of low income to protect themselves as they would not be able to do otherwise against the cost of catastrophic illness. This element is chiefly responsible for the hue and cry for government compulsory health insurance. That demand will not cease until some sort of insurance is furnished the people generally. Unless it is furnished on a voluntary basis such as that provided by commercial insurance companies and the non-profit plans, it will be furnished by the U. S. Government under the plans now proposed by President Truman and Mr. Ewing.

These facts are so plain that they should be evident to any thinking person.

CHICAGO CONFERENCES

More than 250 leaders of state medical societies from across the nation charged with the responsibility of conducting public relations programs to advance public understanding and health care met in Chicago, November 5 and 6. The occasion was the second annual Medical Public Relations Conference sponsored by the American Medical Association and attended by physician chairmen of state medical society public relations committees, lay executive secretaries and public relations directors, and representatives of 20 allied national health organizations.

Dr. Ernest E. Irons of Chicago, president of the Association, told the conference that it was concerned not only with the question of medicine but with that of survival of the American way of life.

"That is why the medical profession must depart from its traditional aloofness from social and political activities," Dr. Irons said. "It must devote itself to the dangers of nationalized medicine and the social state. That is why we must accept a new kind of public relations."

Dr. Irons promised frankness with the press, adding: "We shall see that the press has information when it is timely."

Dr. Louis H. Bauer of Hempstead, N. Y., chairman of the A. M. A. Board of Trustees, told the conference that "it doesn't make so much difference what happens to the doctor under socialized medicine. More important is what is going to happen to the public."

The campaign for paternal state has forced business and professional men into protect their independence, according to Averell Broughton of New York, president of the Public Relations Society of America.

"The best answer to one pressure group, those of the left wing or New Deal, is another pressure group," Mr. Broughton said. "But while it is the army that moves, it is the individual who fights, and it is the many little local campaign that win the big campaign."

He urged doctors to participate in the efforts to keep the profession from losing its independence through socialized medicine legislation.

The adoption of code of cooperation by the medical profession and the press and radio in Colorado was detailed by Dr. McKinnie Phelps of Denver, chairman of the public policy committee, Colorado State Medical Society.

Out of meetings with the working press developed the Colorado Code of Cooperation, under which all the parties acknowledge certain responsibilities. Spokesmen for the medical profession were designated in every area and newspapers and radio stations were supplied names, addresses and telephone numbers.

"Officers, committee chairmen or designated spokesmen of the medical society may be quoted by name in matters of public interest, and often are," Dr. Phelps said. "Such statements by authorized spokesmen are not considered by their colleagues as a breach of the time-honored practice of physicians to avoid personal publicity, since it is done in the best interests of the public and the profession."

"Essentially, news is neither suppressed nor censored. It is rather encouraged, but channeled through devices which see to it that the news is accurate."

Leonard E. Read of Irvington-on-the-Hudson, N. Y., president of the Foundation for Economic Education, and dinner speaker, warned of the spreading "coercive collectivism."

"When the state starts to assume a certain amount of our welfare it assumes certain authority over our lives," Mr. Read said.

He pointed to the collapse of governments in Europe when the "Take" in taxes passed the 25 per cent figure. This has reached 29 per cent in the United States, he said.

Dr. Donald B. Koonce of Wilmington, N. C., chairman of the public relations committee of the Medical Society of the State of North Carolina, told of the rapid development of a public relations program in that state.

"President Truman deserves all the credit," Dr. Koonce said. "If it had not been for the imminent danger of compulsory health insurance it would have

been physically and financially impossible to take the rapid steps in public relations we have."

The favorable results from the establishment of a grievance committee by the Oklahoma State Medical Association was reported by Dr. George H. Garrison of Oklahoma City, president of the association.

Dr. Garrison explained that the primary objective of the committee is to see that the public interest is fairly and honestly served and to correct misunderstandings and abuses which the patients believe have occurred.

Following the announcement of the formation of the committee, which was hailed by the press in editorials and columns, many letters were received, he said adding:

"Surprisingly enough, most of them were not complaints against the members of the profession but rather entreaties for help in obtaining medical care."

As a result, he said, a cooperative program was worked out with private and governmental welfare groups to meet the problem. He also said that every grievance had been satisfactorily adjusted.

Dr. J. H. A. Peck of St. Francis, Kansas, President of the Kansas Medical Society, detailed a program in that state aimed to provide doctors for rural areas. The program besides covering medical care provides for better schools, more scientific farming, the establishment of adequate libraries, attractive parks, effective chambers of commerce and the establishment of churches, businesses and homes.

"Our efforts are directed toward health, but we physicians also are cooperating with our rural communities in those other phases of this program," Dr. Peck said. The emphasis in getting a doctor to practice in a community is to stimulate the community to establish proper medical care facilities that will attract a doctor.

Dr. A. E. Cardle of Minneapolis, chairman of the health education committee of the Minnesota State Medical Association and chairman of the session on "State Society Public Relations Projects," cited the new concept in professional thinking.

"Five years ago, a conference like this would have produced many an unfavorable reaction," Dr. Cardle said. "Commercialism, we would have said. Lowering of ethical standards. Selling medicine like soap."

"We have an important message to give the public now and we cannot overlook the media by which we communicate this message. I do not mean that we should be hypocritical or servile in seeking the co-operation of press and radio. They would be the first to detect and expose any lack of sincerity on our part. But, we should deal with them fairly and honestly, giving out information that is reinforced with facts."

Women's auxiliaries to medical associations are potent factors in the profession's public relations program, according to Dr. C. Allen Payne of Grand Rapids, Mich., chairman of the advisory committee of

the Woman's Auxiliary to the Michigan State Medical Society.

Dr. Percy E. Hopkins of Chicago, chairman of the committee on medical service and public relations program established in 1945. Dr. Hopkins pointed out, however, that the Illinois society has had a program for 26 years. He explained how the public relations committee works with other committees of the state society.

Rhode Island though small in area has an effective program, according to Dr. Charles L. Farrell of Pawtucket, R. I., chairman of the committee on public policy and relations of the Rhode Island Medical Society.

Other participants in the conference were Dr. George F. Lull, general manager and secretary of the A. M. A. who welcomed attendees and emphasized that the 48 states attendance was a "clear-cut indication that the medical profession is convinced of the urgent necessity for an over-all continuing long-range public relations program"; Dr. Max H. Hattaway of New Orleans, chairman of the council on medical service and public relations, Louisiana State Medical Society, and chairman of the session on "Organizing for an Overall Public Relations Program" and Dr. F. S. Winslow of Rochester, N. Y., chairman of the public relations committee, New York Medical Society, and chairman of the session on "Get It Off Your Chest."

The conference was directed by Lawrence W. Rember, public relations director of the A. M. A.

AVAILABILITY AND UTILIZATION OF MEDICAL CARE IN AMERICA*

The lack of factual information on the extent of medical service is evident. The question is frequently asked: "To what extent is medical care now available in the United States? The proponents of Compulsory Health Insurance make claims which the opponents of the system emphatically deny, protesting that such statements should not be made without the ability to produce the evidence in their support. The facts are that neither the supporters nor opponents of Compulsory Health Insurance have factual, comprehensive statistics that the other side will accept. Such material as is available suggests that the allegations of both sides are often based on fragmentary information and often are grossly exaggerated.

Several years ago the Brookings Institution made a preliminary, analytical survey of some aspects of this problem but, because of the lack of reliable, comprehensive data as to the extent to which medical service was available to the people of the United States at that time, that study was necessarily limited

* Address of Dr. George W. Bachman of the Brookings Institution, Washington, D. C., before the Secretaries and Editors Conference of the A. M. A. on November 3, 1949, in Chicago.

to certain issues considered important to compulsory health insurance legislation then before congress. Today, provision for more adequate medical care for the people has become a subject of vital interest and controversy. Because of this interest, the Brookings Institution is now making a study of the availability of medical service in the United States.

Both Government and private agencies are making every effort to extend the availability of medical service to the population. The Federal Administration's emphasis is placed on the legislation of a National Compulsory Health Program, which proposed to provide medical services to 85 per cent of the population. The private agencies, on the other hand, are stressing voluntary prepayment medical care plans, emphasizing the fact that medical care under a free system of medical service can advance faster and better than under a federally controlled system.

The situation in regard to medical programs is rapidly changing. This is true of the medical service plans that are now offered by a wide variety of public and private agencies. The major feature of labor union programs today calls for benefits in the form of pensions and medical care. At the same time, philanthropy continues to be a vast and unknown field in which free and varied medical service is provided. Some of the services now provided may be briefly indicated as they will be emphasized in our study.

The service in the field of private practice undoubtedly covers the larger percentage of the population. Of approximately 165,000 practicing physicians serving on the average of 25 patients a day and with the added facilities of over 6,000 hospitals with an average daily census of over a million persons, the percentage of the population receiving medical care would appear to be larger. In addition, 280,000 nurses and 70,000 dentists contribute to these services.

The service of the private medical agencies have continued to grow in spite of assumption by the government of greater responsibility in this field. If the experience of the past show the way to the future, medical needs, depending upon the extent of governmental control, will continue to be supplied by voluntary prepayment medical care plans, private practices, and private agencies.

There has been a rapid development in the field of industrial medical care within the last few years. It is claimed that there are at present over 20,000 industrial plants providing some measure of medical relief to approximately 32 million people. A large percentage of the labor force is covered by Workmen's Compensation.

There has also been a phenomenal rise in the percentage of people covered under voluntary medical care and hospital plans. These plans have wide differences in methods of sponsorship and financial arrange-

ments. Some are limited to membership, with eligibility confined to special groups, governed by age, physical condition, income, and employment. Some plans are conducted for money profits; others are organized on a nonprofit basis, applying any financial benefits to the provision of additional medical services.

The rapid growth in the number of voluntary insurance plans and the extent of their coverage during the last few years indicate to a certain degree the medical care coverage now available to the American people. Protection provided by commercial insurance companies and nonprofit plans, as of the beginning of the year, covered some 61 million persons against hospital expense, some 34 million against surgical expense, and some 13 million against other medical expense. In addition, some 33 million workers—over half the nation's labor force—were covered by such means against loss of income due to illness. These figures indicate a much greater amount of protection than was in force only a few years ago. The significant fact lies in the changing attitude of the American people in seeking voluntary sickness insurance, as reflected in the remarkable growth of insurance arrangements. The question that naturally arises is, "How effective is this coverage and can voluntary prepayment plans largely eliminate any need for compulsory health insurance?"

The extent of the medical care coverage provided by the philanthropic agencies, including those of the Community Chest, is not known. Among these agencies there are about 20,000 in the United States concerned with the various phases of public health and the prevention and treatment of disease. Some of these agencies, such as the National Tuberculosis Association, Red Cross, etc., are nationally known, while many others are of only local interest. Of the national organizations fourteen or more are concerned with specific problems such as tuberculosis, cancer, infantile paralysis, venereal diseases, aid to the blind or hard of hearing, and the promotion of mental hygiene and maternal and child care programs. While their services are limited to specific problems or groups of people, these organizations reach the medical needs of many.

The governments, federal, state, and local, give various degrees of medical care to many million beneficiaries—estimated to cover about one sixth of the nation's population.

The federal government provides hospital and medical care by various agencies—the armed forces, the Veterans Administration, The Children's Bureau, The Public Health Service, and the Federal Security Agency by public medical assistance benefits. Over seventy-five civilian agencies of the federal government now provide some form of health activities, of which some forty have medical services included within their programs. Federal agencies operate over 200,000 beds in 499 hospitals, dispensaries, and

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domicially homes. The federal agencies employ about 16,000 full-time doctors, 3,000 dentists, nearly 22,000 nurses, and 158,000 other employees assisting in giving medical and health services to an estimated 24,000,000 people.

State medical care depends to a large extent upon the type of illness and the amount of indigency. All states care for the mentally sick. About 85 per cent of all the beds in nervous and mental hospitals are in state hospitals. Thirty-two per cent of the tuberculosis beds and four per cent of the general hospital beds are operated by the states. Local governments also assume responsibility for medical care of persons who become wards of the community.

The scope of the study by the Brookings Institution must be necessarily broad. Workable relationship will need to be established with both private and public agencies. These will include medical and health service provided by industry, trade unions, medical societies, philanthropic and fraternal organizations, insurance carriers, and governmental agencies—including social security, veterans and the armed forces.

The proposed investigation as a whole will be divided into two parts. The first part will be a comprehensive, descriptive, and statistical report designed to make available reliable data on the extent of medical care and the existing and potential provisions for meeting the cost through insurance or payment plans, and, in the case of those who cannot pay, through public services or private philanthropy. The second part, based upon the facts assembled in part one, will be an analysis of the data colled. This analysis will include a comparison of the health resources now available with such criteria as can be developed to measure potential public demand for necessary medical care. The analysis, it is expected, will thus spotlight such gaps in the over-all picture as may exist, and will cover the questions of public and private policy involved in various alternatives for filling these gaps.

A study of this scope and character is a major research undertaking. Fortunately, various groups whose professional interests are involved are willing to extend their co-operation. Among these, medical, dental, hospital, industrial, labor, insurance, religious, and several governmental agencies have offered their assistance. This co-operation is encouraging, as the success of the undertaking will greatly depend upon the collaboration of all agencies responsible for some form of medical service.

The several surveys completed and now anticipated will assist in complementing the study as a whole. It is sincerely hoped that the proposal for a systematic sample survey bearing on medical care and health insurance protection under the auspices of the National Opinion Research Center of the University of Chicago will get under way soon. This study, with its special emphasis on the underlying social and

psychological patterns on which any program of medical insurance must build, should round out the factual part of this study. The nationwide study now under consideration by the University of Pennsylvania, a survey on the economic aspects of medical care of the American family, will likewise add valuable, comprehensive material. The directors of both these surveys have suggested close collaboration and mutual assistance in carrying forward the work of these studies.

As secretaries and editors of the State Medical Associations, and because of your personal interest in the medical care problems of this country, you are in an excellent position to contribute to this study. Your co-operation is therefore, respectfully solicited.

HAWLEY SAYS FSA HIDES COST OF FEDERAL HEALTH INSURANCE

The cost of compulsory health insurance is being carefully kept secret by the Federal Security Administration, according to Dr. Paul R. Hawley, an outstanding leader in the movement for health insurance on a voluntary basis.

Analyzing the issue of compulsory health insurance in Blue Print a quarterly publication of the Blue Cross Commission of the American Hospital Association, he writes: "By two independent methods of approach to the problem, careful investigators have estimated the cost to be \$100 per capita per annum when the program is in full operation. This is \$15,000,000,000 a year. "The payroll deductions and employer contributions fixed by the Federal Security Administration will produce \$6,000,000,000 per year. Thus the contributions to the fund will pay no more than 40 per cent of the cost.

"Here I would point out that this huge cost is not for necessary medical care but largely to satisfy the capricious desire for medical attention for inconsequential ailments. "In the present state of our national budget, can any intelligent citizen advocate adding \$9,000,000,000 per year for the sole purpose of gratifying the demands of neurotics, malingerers, and chislers?"

(The Christian Science Monitor, Sept. 1, 1949)

SOCIALIZING INSURANCE

The United States is headed down the road to Socialism, and the insurance business will be first to come under its rule. That bitterly unpalatable warning was made here by Senator Byrd at the annual meeting of the National Association of Insurance Agents. The Virginian's ominous words are the more credible because we've had a preview in this country during the past decade of socialized insurance.

For example, take social security. The New Deal device collects periodic payments from the individual

and, if he lives long enough, restores this money and more in the form of old age insurance. Annuities do exactly the same thing. The difference is that social security is government-operated and imposed an equal contribution upon the employer; annuities are privately operated and each individual shoulders his own burden.

The various health and welfare plans in industry are semi-socialized insurance. Rammed down management's throat with the eager assistance of a pro-labor administration, they are a far cry from the orthodox private insurance under which each insured person decided whether or not he wishes to be insured, paying the full cost of the premium if he decides affirmatively.

GI life insurance is still another illustration of government insurance. Throughout the war there was ample justification for this coverage. Millions of service men were unable to maintain adequate policies in

non-government insurance companies on a salary of \$50 to \$100 a month. On the other hand it would have been infamous to ask these men to risk their lives in defense of their country without enabling them to make provision for their families' economic future in the event of death or disability.

But the shooting war has been over for more than four years now. And ex-service men are still obtaining coverage through cheap government insurance, competing with commercial insurance. Whatever the merits of the case, this too, is unadulterated Socialism. Moreover, the privately operated insurance companies are regulated with great rigor by the laws of the several states.

In the circumstances Senator Byrd's warning should provoke no skeptical retort. Not only is the insurance business headed down the road to Socialism, but its nose is already through the door.

(Chicago Journal of Commerce, Oct. 3, 1949)

Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT #649

Student H. L. Scofield, presenting:

PRESENT ILLNESS: The patient, a 44 year old colored male, was admitted February 11 with chief complaints of shortness of breath and hoarseness. The onset of his symptoms began in September when he noticed that his voice was becoming weaker and that he was hoarse. This condition progressed rapidly and his voice never regained its full volume. He continued to work until December and then developed a cough with dyspnea on exertion and during the night, tachycardia, precordial pain, malaise and anorexia. These complaints persisted. There was a total weight loss of 23 lbs.

Review of family history revealed that his father had died at an unknown age of heart trouble.

PAST HISTORY: This patient had gonorrhea in 1923 and said to have had syphilis in 1925.

PHYSICAL EXAMINATION: T 96, P 80, R 26, BP, left arm, 120/65. BP in right arm could not be obtained. Patient was acutely and severely ill, extremely emaciated and poorly developed. Unable to speak above a whisper. Respirations noisy and labored. Tracheal tug present. There was wheezing over the lung fields with suppressed breath sounds in the right lower chest and moist rales in the bases. There was questionable widening of the mediastinum on percussion. PMI was in the seventh intercostal space in the left anterior axillary line. Heart sounds were forceful and regular with a palpable thrill over the entire precordium. Loud scraping systolic murmur at the apex transmitted up to the sternum with a diastolic murmur along the sternal margin in the

aortic region. Venous distention was noted generally. The liver was 3 cms. below the costal margin. Reflexes appeared hypoaactive.

LABORATORY DATA: Blood: 2 11 — RBC 3.8 million, WBC 10,650, hemoglobin 10 gms. Differential 77 polys, 23 lymphs. Blood sedimentation rate 26. Blood Wassermann and Kline positive. No evidence of sickling. Urine: Sp. Gr. 1.027 and 1.021. Positive for albumin. Occasional WBC. Occasional hyaline cast. Stool examination negative. X-rays available.

COURSE IN HOSPITAL: Patient was admitted in extremely poor condition. On February 17 cervical veins were seen to be greatly distended and there was periorbital edema of the face. There was moderate respiratory obstruction with asthmatic type breathing. On 2 19 the patient expired.

Dr. J. A. Boone, Conducting: Mr. Gibson, please give us your analysis of this case.

Student Gibson: The story here resolves itself into two parts, the presence of a mediastinal mass and some involvement of the heart. An aortic aneurysm is certainly the most likely possibility as regards the former. A negro male, 44 years of age with a history of syphilis and positive Wassermann immediately suggests this lesion. Hoarseness, cough, absence of blood pressure in one arm, tracheal tug, and possible widening of the mediastinum can all be explained on the basis of aneurysm and are common symptoms and signs of this condition.

There also seems to be an element of congestive heart failure. Many of the symptoms could be produced by either the aneurysm or cardiac failure, but the dyspnea, distended neck veins, enlarged liver,

precordial pain and pulmonary rales are more fitting to congestive failure. The PMI in the seventh intercostal space points to marked enlargement of the heart. Very commonly the syphilitic aortitis which is responsible for the aneurysm also involves the root of the aorta with deformity of the valves. The resulting aortic insufficiency would account for the diastolic murmur and eventual heart failure. As the heart dilated and failed there would be dilatation of the mitral valve ring and this could produce the systolic murmur and even the thrill. He may also have had narrowing of the coronary ostia that would aggravate the heart failure and might result in sudden death. The immediate cause of death is more likely rupture of the aneurysm into the trachea, bronchus or pericardial sac.

Dr. Boone: Please give us your impression of the chest x-rays.

Student Gibson: There is a dense bulging mass extending from the mediastinum into the left lung field. There is also prominence of the right side of the mediastinum. The heart doesn't appear appreciably enlarged.

Later films show the same changes and an additional dense shadow in the upper part of the left lung. I'm not sure of the significance of this.

Dr. Boone: What do you think about the elevated sedimentation rate?

Student Gibson: I think this could be due to the tertiary syphilis.

Dr. Boone: Mr. Levi, do you agree?

Student Levi: I agree that it is a mediastinal tumor either aneurysm or neoplasm. Fluoroscopy would be important in differentiation of the two. If the mass pulsed then aneurysm becomes the definite diagnosis.

The dense shadow in the upper portion of the left lung could be an infarct or more likely leakage from the aneurysm with calcification of the hematoma.

Dr. Boone: Do you see any vertebral erosion in the lateral films?

Student Levi: Not definitely.

Dr. Boone: I would like to have comments from the attending staff.

Dr. Moseley: Aneurysm appears to be the only possibility from the information here.

Dr. Kelley McKee: The dense shadow on the x-ray films intrigues me. It is not present in the previous films and appears very dense for an accumulation of blood that has had only two months to calcify. I wonder if it is not one of "good-luck" bags that many of the negro patients wear about their necks.

Dr. Pettit: The dense shadow over the upper portion of the left lung is definitely on the skin surface in the lateral films. Doctor McKee's suggestion is a good one.

Dr. Gazes: The marked venous distention and the loud scraping systolic murmur is unusual and I wonder if he did not have rupture of the aneurysm into the superior vena cava. There is usually a humming murmur in such an event, but such a murmur as we have here is not inconsistent. I believe he had an arterio-venous communication.

Dr. Boone: I think an elevated sedimentation rate from tertiary syphilis alone is very unusual. I think he had some other disease process or infection due to obstruction of bronchi or trachea. He probably died of some internal rupture of the aneurysm.

Dr. Montgomery: I wonder why a man with a pulseless arm should have no pain whereas arteriosclerotic changes of sufficient degree to obliterate the pulse is usually associated with pain.

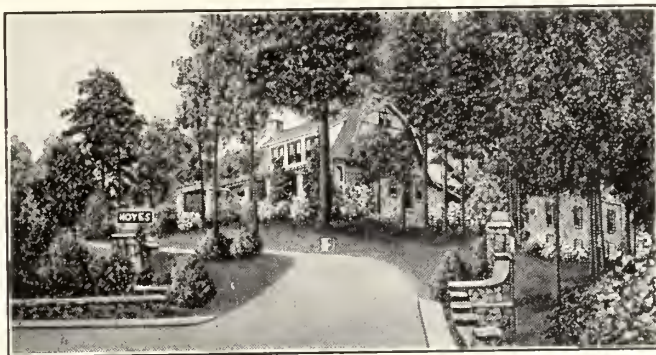
Dr. Boone: This is probably a question of collateral circulation. In arteriosclerosis there is a more diffuse involvement of the vessels and the ischemia cannot be relieved by collateral vessels as is the case here.

Dr. Lynch: There are no signs of massive hemorrhage here and I doubt if he died of internal hemorrhage.

Dr. Edward McKee: Final Pathological Diagnosis: Aneurysms, Syphilitic, of Aorta with Compression and Perforation of Pulmonary Artery. Cor Pulmonale.

This patient had two syphilitic aneurysms of the aorta, one involving the ascending portion and the other the transverse arch. The latter compressed the left branch of the pulmonary artery and ruptured into this vessel. At autopsy the greatest transverse diameter of the pericardium was 14 cms. and there was a saccular mass 10 cms. in diameter occupying the superior mediastinum and extending up into the right sternoclavicular junction. The epicardial surfaces showed scattered areas of roughening. The endocardial surfaces were smooth and glistening. The valve rings were of normal size and the valve leaflets showed no unusual changes. The right side of the heart was markedly enlarged, the wall of the right ventricle measuring 6 mm. in thickness while the wall of the left ventricle measured 11 mm. The intimal surface of the aorta showed the typical tree-barking of syphilitic aortitis and 5 cms. above the aortic ring there was an aneurysmal dilatation, saccular in type, 10 cms. in greatest diameter and filled with laminated thrombus. This aneurysm extended up to the origin of the innominate artery but did not directly involve this vessel. The aneurysmal sac compressed the superior vena cava, the right pulmonary artery, the trachea, and appeared to have distorted the lumen of the innominate artery so as to cause an appreciable stenosis. Examination of the trachea at this level revealed kissing ulcers of the tracheal mucosal one located on the anterior surface and the other directly opposing it on the posterior surface.

Following the course of the aorta there is an irregular defect in the floor of the transverse arch



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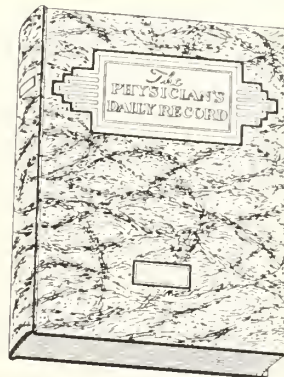
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which measures $2\frac{1}{2} \times 3\frac{1}{2}$ cms. This defect communicates with a second saccular aneurysm measuring $3\frac{1}{2} \times 6\frac{1}{2}$ cms. which extends into and is closely adherent to the mesial portion of the left upper lobe of the lung. This second aneurysmal sac has a much thinner wall and is adherent to the left branch of the pulmonary artery, compresses the lumen of this vessel, and shows a .5 cm. defect opening into the lumen of the pulmonary artery just above the bifurcation of this vessel. The lungs both show dense pleural adhesions and in the left upper lobe there is a wedge shaped area of consolidation measuring 2×3 cms. which on sectioning proves to be an area of infarction. There is congestion and edema of the parenchyma which is most marked throughout the

right lung. Microscopic examination verifies the gross diagnosis of syphilitic aortitis and otherwise as well as congestion and edema of the lungs with early lobular pneumonia.

The autopsy records of this Department reveal that some 150 cases of aneurysms have been examined and this is the first instance in which an aneurysm has ruptured into the pulmonary artery. Subsequent to the performance of this autopsy we have had another case which may represent this same phenomenon. The syndrome of syphilitic aneurysm of the aorta rupturing into the pulmonary artery is a recognized one and to date roughly 40 cases of this type have been described.

SOUTH CAROLINIANA

J. I. WARING, M.D., CHARLESTON, S. C.

This department has been dormant so long that its proper material has accumulated to a rather overwhelming extent. In order to spare everybody considerable effort, a simple list has been made of the articles published by South Carolinians in 1948, and a beginning has been made on the publications of the current year.

Dr. Edward Parker has kindly agreed to take care of the abstracting of surgical matters, and the staff of the Library of the Medical College is kind enough to note and list articles as they appear. Abstracts written by authors themselves will be most welcome, and suggestions will be received with pleasure.

PUBLICATIONS IN 1948

BRANFORD, W. V. (Dillon): Acute epigastric pain and blood amylase activity. (South. Med. & Surg. 110:41-44, Feb., 1948)

BRUNSON, G. W., & FOCHE, J. W. (Columbia): A case of bronchogenic adenocarcinoma. (Recorder 12:13, Aug., 1948)

BURN, E. M. (Columbia): Migraine headache. (Recorder 12:12-16, Nov. 1948)

BURNSIDE, A. F. (Columbia): An evaluation of the treatment of endometriosis. (South. Surg. 14:645-650, Sept., 1948)

CANTEY, W. C., & KINDER, E. C. (Columbia): Intestinal obstruction due to endometriosis. (Recorder 13:6-9, 23, July, 1949)

COLVIN, E. M., & WALLACE, F. T. (Spartanburg): Gastrostomy and intestinal tube feedings as an aid in gastric surgery. (South. Surg. 14:709-714, October, 1948)

COLVIN, E. M., & WALLACE, F. T. (Spartanburg): Chemotherapy in peritonitis due to perforation of an abdominal viscus. (S. G. & O. 87:440-444, Oct., 1948)

EVATT, C. W. (Charleston): Ophthalmology and the general practitioner. (South. Med. & Surg. 111:63-64, March, 1949)

HANNA, C. B., & PRATT-THOMAS, H. R. (Charleston): Extragenital granuloma venereum. (South Med. J. 41:776-782, Sept., 1948)

HART, W. A. (Columbia): Elizabeth Blackwell. (Recorder 13:23-26, September, 1949)

HARVIN, J. R., HASTINGS, W. D. Jr., & BAKER, C. R. F. (Sunter): Tetanus neonatorum. (J. of pediatrics 32:561-563, May, 1948)

HAYNE, J. A. (Columbia): Some thoughts on geriatrics. (South. Med. & Surg. 110:170-173, June, 1948)

HOCH, J. H. (Charleston): Fifty years of quantitative microscopy in pharmacognosy. (Economic Botany 2:111-116, Jan.-Mar., 1948)

HODGE, G. B. (Spartanburg): The electrocardiogram in biliary tract disease and during experimental biliary distention, by G. B. Hodge and A. L. Messer. (S. G. & O. 86:617-626, May, 1948)

HUGGIN, K. B. (Columbia): The use of streptomycin in the treatment of tuberculosis. (Recorder 12:16-18, Aug., 1948)

HUGGIN, P. M. (Columbia): Streptomycin in the treatment of tuberculosis. (Recorder 13:19-20, Sept., 1949)

HUGGIN, P. M. (Columbia): Lymphoblastomatous disease of mycosis fungoides variety. (abstract). (Recorder 12:9-11, August, 1948)

JERVEY, J. W. (Greenville): Heresies and ethics in ophthalmology. (South. Med. J. 41:514-518, June, 1948)

LASSEK, A. M., & HARD, W. L. (Charleston): The pyramidal tract. A study of the sensitivity of neurons to trauma in the rat with a comparison of methods. (J. Neuropath. & Exper. Neurol. 7:457-461, Oct., 1948)

- LEMMON, C. J., Jr., & FREED, J. (Columbia): Preliminary report of prefrontal leukotomy cases at the S. C. State Hospital. (Recorder 12:11-13, June, 1948)
- LINTON, I. G. (Charleston): Further consideration of postoperative ambulation. (South. Med. & Surg. 110:174-175, June, 1948)
- LYNCH, K. M., & CANNON, W. M. (Charleston): Asbestosis: VI. Analysis of 40 necropsied cases. (Dis. Chest 14:874-888, Nov.-Dec., 1948)
- MCCORD, W. M., SWITZER, P. K., & BRILL, H. H. (Charleston): Isopropyl alcohol intoxication. (South. Med. J. 41:639-642, July, 1948)
- MACINNIS, K. B. (Columbia): Antihistaminics. (Recorder 12:7-11, Dec., 1948)
- MADDEN, L. E. (Columbia): Carlos Juan Finlay and yellow fever. (Recorder 12:19-20, Aug., 1948)
- MOORE, A. T. (Columbia): Some facts of Alaska—medical and otherwise. (Recorder 12:13-17, Dec., 1948)
- MOORE, A. T. (Columbia): Traumatic radiculitis in low back pain. (South. Med. J. 41:1065-1076, Dec., 1948)
- MOREHOUSE, W. G. (Columbia): The involutional psychoses. (Recorder 13:11-16, Sept., 1949)
- MOSELEY, V. (Charleston): The use of tripelenamine hydrochloride (pyribenzamine) as a topical anesthetic. (Amer. J. Diges. Diseases 15:410-411, December, 1948)
- PARKER, E. F., & BROWN, A. G. (Charleston): Epidermoid cyst of the spleen. (Surgery 24:708-713, Oct., 1948)
- PRICE, J. P. (Florence): I had a case. (South. Med. J. 41:557-561, June, 1948)
- PRIOLEAU, W. H. (Charleston): Operability of thyroid cases. (South. Surg. 14:283-285, Apr., 1948)
- RAVENEL, W. J. (Charleston): A brief sketch of tattooing with one method of its removal. (South. Med. & Surg. 110:238-239, Aug., 1948)
- RILEY, K. A. (Charleston): Untoward reactions and cutaneous testing in penicillin therapy, by Joseph Farrington, Kathleen Riley and Sidney Olansky. (South. Med. J. 41:614-620, July, 1948)
- SEIBELS, R. E. (Columbia): Cytology: a diagnostic method in early carcinoma of the cervix. (South. Med. J. 41:706-711, Aug., 1948)
- SIEGLING, J. A. (Charleston): Progress in orthopedic surgery for 1946. XIV. Diseases of growing and adult bone. (Arch. of Surg. 58:541-546, April, 1949)
- SMITHY, H. G., PRATT-THOMAS, H. R., & DEYERLE, H. P. (Charleston): Aortic valvulotomy: experimental methods and early results. (S. G. O. 86:513-523, May, 1948)
- SMITHY, H. G.: The control of arrhythmias occurring during operations upon the valves of the heart: experimental and clinical observations. (South. Surg. 14:611-618, Sept., 1948)
- SWITZER, P. K., & FOUCHE, H. H. (Charleston): The sickle cell trait: incidence and influence in pregnant colored women. (Amer. J. Med. Sci. 216:330-332, Sept., 1948)
- TAFI, R. B. (Charleston): Editorial: Primum non nocere. (Radiology 51:875, Dec., 1948)
- WALLACE, F. T., & COLVIN, E. M. (Spartanburg): Complications of imperforate anus repair. (Surgery 24:832-835, Nov., 1948)
- WALLACE, F. T., & COLVIN, E. M. (Spartanburg): Perforations of the colon—non-traumatic. (South. Med. & Surg. 110:135-137, 140, May, 1948)
- WALTON, R. P. (Charleston): The medical film institute of the Association of American medical colleges, by Walter A. Bloedorn, J. E. Markee and R. P. Walton. (J. A. A. M. C. 23:361-370, Nov., 1948)
- WHITE, J. W. (Greenville): Progress in orthopedic surgery for 1946. XIII. Amputations, apparatus and technic. (Arch. of Surg. 58:399-410, Mar., 1949)
- WILSON, D. A. (Greenville): Extrapleural pneumolysis with lucite plombage. (J. Thorac. Surg. 17:111-122, Feb., 1948)
- WILSON, R. (Charleston): Unorthodox treatment in coronary occlusion. (South. Med. & Surg. 110:106-108, April, 1948)
- WYATT, C. N. (Greenville): Presidential address, Tri-State medical association. (South. Med. & Surg. 111:61-62, March, 1949)
- YOUNG, J. R. (Anderson): Mesenteric lymphadenitis in childhood. (South. Surg. 14:225-226, March, 1948)

(SOUTH CAROLINIANA)

1949

- JOSEY, A. I. (Columbia): Headache associated with pathologic changes in cervical part of spine. (J. A. M. A. 140:944-949, July 16, 1949)

A group of patients with frequent and recurrent headache, beginning in the occipital region, showed a characteristic loss of normal lordotic curvature in the cervical spine. Sprain of the upper cervical spine is the probable basis. Treatment is unsatisfactory.

- PRATT-THOMAS, H. R., & SWITZER, P. K. (Charleston): Sicklemia: Its pathological and clinical significance. (South. Med. J. 42:376-383, May, 1949)

The authors found sicklemia in nearly 5% and sickle cell anemia in over 1% of negroes from the South Carolina coast. They believe that sicklemia is responsible at times for lesions and untoward results in conditions which produce a lowering oxygen tension. Cases are reported.

RILEY, K. A. (Charleston): Monilial infection of the thumb nail; report of a case. (Arch. Derm. & Syph. 59:589-590, May, 1949)

An infection traced to thumb sucking and treated successfully with potassium permanganate, gentian violet (10%), and sodium propionate ointment.

SEIBELS, R. E., jt., author (Columbia): Efficacy of

the suppository and of jelly alone as contraceptive agents, by N. J. Eastman (Baltimore) and R. E. Seibels. (J. A. M. A. 139:16-20, Jan. 1, 1949)

Granting the difficulty of evaluating data in a study such as this one, and granting that the personal factors involved are as important as the inherent efficacy of the procedure used, the authors conclude that the suppository is probably as effective as the diaphragm in contraception.

NEWS ITEMS

Dr. Carolina H. Callison, Abbeville, has recently passed the examinations and been certified by the American Board of Preventive Medicine and Public Health.

Dr. William H. Hall announces the opening of his office in Sumter for the practice of Pediatrics.

Dr. James T. Hardy announces the opening of his office in Columbia for the practice of Internal Medicine, Bronchoscopy and Esophagoscopy.

Dr. Frank H. Stelling announces the opening of his office in Greenville for the practice of Surgery. Dr. Stelling has succeeded Dr. Warren White as Chief Surgeon at the Shriners' Hospital for Crippled Children in Greenville.

Dr. C. Benton Burns announces the opening of his office in Sumter for the practice of Pediatrics.

Dr. Wm. S. Brockington announces the opening of his office in Greenwood for the practice of Surgery.

"A two-day Sectional Meeting of the American College of Surgeons is to be held at the Belleview-Biltmore Hotel, Belleair, Florida, on January 9 and 10. The section consists of the states of Virginia, North Carolina, South Carolina, Georgia, Mississippi, Alabama, and Florida. This meeting will consist of all day and evening conferences on timely surgical subjects and separate meetings for hospital personnel where hospital problems will be considered at panels and round table discussions.

The surgical program will include some new surgical motion picture films, papers and panels on such subjects as: Arterial Lesions of the Extremities, Hormone Therapy in Breast Lesions, Intestinal Obstruction, Gastric and Intestinal Intubation, Treatment of Head Injuries, Surgery of the Hand, Surgical Lesions of the Stomach, Caesarean Section, Management of Uterine Prolapse, the Management of Traumatic Conditions, and a Symposium on Cancer.

Members of the South Carolina Medical Association and personnel of South Carolina hospitals are invited to attend this meeting. The Fellows of the College in Florida wish to assure all visitors that adequate hotel accommodations will be available and that they will be made most welcome at all of the sessions."

F. A. C. S.

The following surgeons have recently been made Fellows of The American College of Surgeons—
LeGrand Able ----- Spartanburg

William S. Brockington ----- Charleston
James W. Fouché ----- Columbia
Jack D. Parker ----- Greenville
Raymond W. Postlethwait ----- Charleston
Keitt H. Smith ----- Greenville
Roger A. Way ----- Spartanburg
David A. Wilson ----- Greenville

DEATHS

JOHN B. SETZLER

Dr. John B. Setzler, 69, died suddenly in his automobile from a heart attack on November 10.

A native South Carolinian, Dr. Setzler received his education at Newberry College and at the Medical College of Virginia. Following a period of general practice at Newberry, Dr. Setzler entered public health service and served as county health officer in Dillon county for several years. Following this he served as medical director of the Carolina Life Insurance Company. In 1943 he returned to public health work and was director of the Spartanburg County Health Department until his untimely death.

A veteran of World War I, Dr. Setzler was very active in the work of the American Legion, serving as commander of Richland Post in 1933-34. He was also active in the work of the Red Cross and of the Y. M. C. A.

ROBERT HENRY WILDS

Dr. Robert H. Wilds, 66, died at the Aiken County Hospital on November 1 after an illness of several months.

A native of Aiken County, Dr. Wilds received his education at the University of South Carolina and at the College of P. and S. at Columbia University (class 1910). He entered the medical corps of the Army in 1912 and served until 1920, following which he located in Aiken where he practiced medicine until his final illness. At the time of his passing, he was Chief of Staff of the Aiken County Hospital.

Dr. Wilds is survived by six children and four grandchildren.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. J. L. Sanders, Greenville, S. C.

Publicity Secretary: Mrs. Kirby D. Shealy, Columbia, S. C.

1949 CONFERENCE OF STATE PRESIDENTS AND PRESIDENTS-ELECT AND NATIONAL CHAIRMEN OF STANDING COMMITTEES

Thursday and Friday—Nov. 3rd and 4th, 1949

Hotel Lasalle, Chicago

Conference Theme—"A.M.A. 12 Point Program"

The importance to a President of attending the Conference can't be overestimated. The meeting attended in Chicago November 2nd and 3rd was of outstanding interest, with a wealth of information.

South Carolina stands at the top in Auxiliary activities, and the close cooperation and support of the S. C. Medical Association was very evident. Socialized medicine and compulsory health insurance consumed much time and discussion. Due to this fact the presidents were requested to mail their reports to the National President by November 9th, in order that they may be printed in the December Bulletin.

The States having Auxiliary Bulletins were the only reports given by the State Presidents. It was with much pride that I gave this report. "Stating that though the South Carolina Bulletin was in its infancy being just two years old, its face had been lifted this year from mimeograph to printed pages, was financed by our South Carolina Medical Association, compiled and published through the Director of Public Relations and Council of the South Carolina Medical Association Mr. M. L. Meadors of Florence, S. C. and Mrs. David F. Adecock of Columbia, S. C. Bulletin chairman for Woman's Auxiliary to the South Carolina Medical Association. I stated the bulletin was indispensable in transmitting to and receiving information from the county Auxiliaries, and I had received several inquiries pertaining to operation of our publication."

State presidents were urged to secure Resolutions from all civic clubs, church groups, P.T.A.'s, A.A.U.W., American Legion, etc. opposing compulsory health insurance. This to be done on the advice and approval of State and local Advisory Council's. Dr. C. Ivy, Vice President of the University of Illinois congratulated the south on its contribution during an A.A.U.W. convention there, for going on record as opposing compulsory insurance and for not having any racial prejudices.

After visiting the National Education Campaign Headquarters I am more concerned that each auxiliary should make concerted efforts to place "the Doctor" picture in every doctors office in our State. There is no limit on the number of pictures, so I urge you to order them or give me the number needed with the names and addresses of your doctors, and they will be sent direct from Headquarters.

Mrs. J. L. Sanders, President

THIRD DISTRICT MEETS

The Woman's Auxiliary to the Third District Medical Society held its first meeting of the year at the community hall in Newberry on November 1. The Third District includes Greenwood, Ninety-Six, Abbeville, Newberry, and McCormick.

Mrs. Able introduced the speaker of the occasion, Dr. Buck Pressly of Due West, who spoke on medical

education and its crucial situation at the present time. There are 72 medical schools in the United States and only one out of every eight applicants are accepted, he said. South Carolina has one doctor for every 701 persons, he pointed out. He stressed the need for medical auxiliaries and the part they can play among the American people.

Mrs. Gordon Able of Newberry, president, called the meeting to order. Mrs. Jack Bell called the roll in the absence of the secretary, Mrs. Jack Scurry. Twenty members were present. The president reported that she and Mrs. M. J. Boggs of Abbeville had attended the executive board meeting in Greenville on October 5.

Two new members, Mrs. V. W. Rinehart of Newberry, and Mrs. D. A. Long of Prosperity were welcomed into the Auxiliary.

At the conclusion of the business the meeting was turned over to Mrs. Boggs who introduced Mrs. David F. Adecock of Columbia who is co-chairman of publicity for the South Carolina Medical Auxiliary and past president of the organization. She gave a short talk on the Auxiliary Bulletin, the duties of the Historian and mentioned the development of a speakers bureau.

Luncheon was served from tables appointed with pumpkin jack-o-lanterns filled with fruit. Autumn leaves were also used on the tables which were decorated by Mrs. J. E. Dickert of Newberry.

EXECUTIVE BOARD ENTERTAINS NEW MEMBERS

The Executive Board of the Woman's Auxiliary to the Columbia Medical Society met Thursday morning, October 27, at the home of Mrs. Wilson Ball, president-elect. Mrs. William Weston, Jr., president, presided. Members of the board include: Mrs. T. J. Hopkins, vice president; Mrs. J. E. Holler, recording secretary; Mrs. George W. Brunson, corresponding secretary; and Mrs. H. H. Plowden, treasurer.

Reports of the various activities of the Auxiliary were given by the following committee chairmen:

Courtesy	Mrs. E. C. Kinder
Decorations	Mrs. David Asbill
Entertainment	Mrs. Weston Cook
Historian	Mrs. D. F. Adecock
Hygeia	Mrs. M. B. Hook
James Todd Crawford	Mrs. W. A. Hart
Legislative	Mrs. M. E. Hutchinson
Membership	Mrs. Ben Miller
Nominating	Mrs. H. L. Timmons
Parliamentarian	Mrs. T. A. Pitts
Program	Mrs. Izard Josey
Public Relations	Mrs. Malcolm Mosteller and Mrs. Wilson Ball

Publicity	Mrs. J. E. Freed
Student Loan Fund	Mrs. I. J. Mikell
Telephone	Mrs. R. L. Sanders
Nurse Recruitment	Mrs. Roy G. Smarr

Following the business session the new members and applicant members were guests of the board at a lovely tea. Those invited were: Mrs. Edward M. Burn, Mrs. George W. Smith, Mrs. William C. McLain, Jr., Mrs. Charles B. Whitaker, Mrs. Bothwell Graham, Mrs. Edward D. Andrews, Mrs. Chapin

Hawley, Mrs. T. Marion Davis, Mrs. Blease Floyd, Mrs. W. G. Morehouse, Mrs. James T. Hardy, Mrs. James T. Quattlebaum, Mrs. John Wallace, Mrs. Carl G. Culley.

COLUMBIA AUXILIARY MEETS

The Woman's Auxiliary to the Columbia Medical Society held its first meeting of the year Tuesday, November 8, at the Forest Lake Country Club. William Weston, Jr., president, presided.

After the reading of the minutes by Mrs. John Holler and the treasurer's report by Mrs. H. H. Plowden, reports from committee chairmen were heard. In the absence of Mrs. W. A. Hart, chairman of the Jane Todd Crawford Loan Fund, Mrs. H. L. Timmons gave the report and explained that a loan fund had been set aside for scholarships for the training of nurses. Girls wishing this aid should contact Mrs. W. A. Hart. Mrs. Roderick MacDonald of Rick Hill is the state chairman and recommendations will be sent to her.

The Auxiliary pledged its support to the State Maternal Health program, and went on record as endorsing the smoke abatement ordinance which is to come up before city council within a few days.

Mrs. Ben Miller, membership chairman, announced that the Auxiliary has seven new members and eleven applicant members. Those present were: Mrs. James T. Quattlebaum, Mrs. W. G. Morehouse, Mrs. Paul Wheeler, Mrs. John Wallace, Mrs. James T. Hardy.

Mrs. Izard Josey, program chairman, introduced Miss Madge Graydon, District Physical Therapist of the State Board of Health who spoke to the Auxiliary on the work being done for the orthopedically handicapped children in South Carolina. Miss Graydon told of the work done by the volunteer organizations which are ready to help crippled children. These volunteer organizations include the National Foundation for Infantile Paralysis, the Crippled Children's Society, and the State Board of Health. Miss Graydon showed pictures of children at some of the orthopedic camps which are held for two months during the summer. These camps were started in 1945 and now take care of 394 or more children each summer.

At the conclusion of the program a luncheon was served. The tables were artistically decorated in the Thanksgiving motif. Hand painted name cards were given each member. The committee in charge of the luncheon were Mrs. Weston Cook, Mrs. Chapman J. Milling, Mrs. Gordon Seastrunk, and Mrs. C. Tucker Weston, Jr.

Guests at the luncheon were Dr. Manly E. Hutchinson, Dr. T. M. DuBose, Jr., and Dr. Edith E. Haynes, members of the advisory board from the Columbia Medical Society. Other guests were: Mrs. Charles Kendall and Mrs. Albert Hargiss of Fort Jackson.

MRS. I. A. BIGGER PRESENTS PROGRAM FOR MEETING OF MEDICAL AUXILIARY

Mrs. I. A. Bigger was speaker at the November meeting of the York County Medical Auxiliary at the home of Mrs. Frank Strait on College Avenue.

Mrs. Bigger gave interesting personal allusions to the late Dr. J. Marion Sims, a native of Lancaster who became one of the nation's foremost gynecologists. Mrs.

Alton Brown presented Mrs. Bigger.

Mrs. Gaston Quantz presided. Mrs. W. W. Fennell, Jr., gave the report of the secretary. Mrs. Rufus Bratton, vice-president, gave information concerning the blood bank program. Members of the chapter voted to give \$5 to the United Fund.

Mrs. Roderick MacDonald reported on the recent state-wide board meeting held in Greenville. Mrs. Frank Gaston told of plans for the Christmas party to be given in December for the student nurses at York County Hospital.

Mrs. Quantz announced that Dr. Frank Strait and Dr. Alton Brown would serve as advisors to the Medical Auxiliary.

Guests were invited into the dining room for refreshments. Assisting Mrs. Strait in serving a dainty tea course were Mesdames Rosa G. Strait, Rosa B. Guess and Miss Rosa Lillian Strait.

The home was beautiful with arrangements of chrysanthemums.

TOCCOA DOCTOR IS HEARD BY LOCAL MEDICAL GROUPS

Dr. Bruce Shaeffer of Toccoa, a member of the International College of Surgeons, was guest speaker at the joint meeting of the Anderson County Medical Society and the Anderson County Medical Auxiliary at the Memorial Hospital. He spoke interestingly of his recent six-weeks trip to Europe where he attended a meeting of surgeons.

Dr. Clyde Bowie, who presided, introduced Dr. Schaeffer.

Pointing out the effect of various socialistic governments on the field of medicine, Dr. Schaeffer cited conditions in England, Belgium, France, and Austria, countries which he visited while abroad.

He described conditions in the medical profession as being worse in England than any of the other countries. Conditions in France, he pointed out, were also unsatisfactory, while the medical profession in Belgium, not socialized, seemed very prosperous.

While in Vienna he noted that Austria, socialistic to a certain extent, demanded only eight hours a day from the doctors, the rest of their time to be spent in private practice.

Following Dr. Schaeffer's address, members of the auxiliary invited the doctors into the hospital parlor for a social hour.

Dr. Edwin Ridgeway of Royston, Ga. was among out-of-town guests.

MEDICAL AUXILIARY ENDORSES SMOKE CONTROL ORDINANCE

The Woman's Auxiliary of the Columbia Medical society has given its endorsement to the adoption, of a smoke control ordinance when the matter is presented to city council on November 15, W. O. Blackstone, chairman of the smoke abatement committee, announced yesterday.

In a letter to Mr. Blackstone, Mrs. William Weston, Jr., president, said, "For the sake of the health of the residents (particularly the health of young children and of those subject to bronchial disorders) and for the sake of cleanliness, we are heartily in favor of the smoke abatement program."

The following have paid their \$25.00 A. M. A. Assessment July 1, 1949 to
November 15, 1949

ANDREWS Robert D. Harper	GREENVILLE J. L. Anderson Chas. E. Carpenter J. W. Clatworthy E. E. Cooley (20.00) John K. Webb	R. W. Lominack
BARNWELL Ralph E. Brown	GREENWOOD John C. Scurry R. Brooks Scurry	PAGELAND J. O. Fulenwider, Jr. D. C. Griggs
BISHOPVILLE Robert D. Hicks	FLORENCE Geo. T. Noel	PICKENS J. B. White
CHARLESTON Hugh Cathcart H. S. Pettit Robt. B. Gantt D. L. Maguire	GREER L. M. Davis W. M. Snoddy, Jr.	PIEDMONT J. P. Jewell
CHESNEE Frank W. Ryan Thos. E. Ryan	HARTSVILLE W. L. Byerly	RIDGELAND John O. Ryan
COLUMBIA Wm. H. Corbett, Jr. Walter R. Graham Coyt Ham H. M. Johnson Malcolm Mosteller Catherine N. Munro F. C. Owens B. Rubinowitz J. Graham Shaw Jas. B. Watson	KERSHAW J. M. Brewer KINGSTREE J. M. Brice Foster H. Young	SPARTANBURG D. C. Alford M. H. Allen S. O. Black, Jr. W. N. Coehran Geo. D. Johnson Henry E. Plenge Ruth S. Plenge
COWPENS Robt. H. Crow	LAURENS J. F. Dusenberry Robt. P. McGowan M. B. Nickles M. M. Teague	TIMMONSVILLE J. F. Davenport D. O. Holman
ESTILL John A. Wertz	LORIS J. D. Thomas, Sr. J. D. Thomas, Jr.	TRAVELER'S REST Stanley I. Coleman
FAIRFAX W. R. Tuten, Sr.	LYNCHBURG B. M. Oliver	WARE SHOALS F. C. McLane
JOANNA D. R. McFadden	NEWBERRY Edw. G. Able	WOODRUFF A. S. Pearson
		Out of State Members Harold J. Bowen L. B. Keels



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CORRESPONDENCE

October 4, 1949

Dr. Julian Price
Florence, South Carolina
Dear Dr. Price:

I am trying to locate for purchase or rental for a period of six months or a year a binocular microscope.

If you can help me I will certainly appreciate it.

Sincerely yours,
J. H. Crooks, M. D.

November 4, 1949

To the Editor:

There have been many inquiries recently regarding the arrangements for covering the cost of care for poliomyelitis patients. There are a number of factors which will be of interest to your readers.

During 1949 a poliomyelitis incidence of unprecedented size (more than 37,000 stricken since January 1) has put serious financial strain upon the National Foundation for Infantile Paralysis. For the first time in its eleven year history it was necessary to conduct a Polio Epidemic Emergency Drive which although very helpful did not entirely meet current needs.

In its avowed purpose to lead, direct and unify the national fight against infantile paralysis the National Foundation undertook support of research and education, for in these areas lie the ultimate hope for eradication of poliomyelitis. These programs are not to be compromised in any way.

The greatest cost to the National Foundation, how-

ever, is payment for medical care to patients. It is urgent for all physicians to assist in the institution of measures which will reduce costs without prejudice to patients. The chief costs are for hospitalization. Many poliomyelitis patients are hospitalized when they can be cared for at home at a reduced cost.

Our experience in this year's epidemic which has spared virtually no part of the country suggests the following:

1. Abortive, nonparalytic and mildly paralytic poliomyelitis patients are being hospitalized in the mistaken idea that the stated period of isolation must be spent in the hospital.

2. Overly prolonged hospitalization is frequent. This is particularly true of the paralytic patient who has achieved maximum improvement from daily physical therapy. Home care with periodic office or clinic visits is then in order.

3. There still exists in some places a general attitude that poliomyelitis is a bizarre disease which only a few physicians can manage. This is not so. It is disturbing, for example, to find physicians leaning so heavily upon the guidance of physical therapists and nurses. The physician's assessment of the total patient is the best index in determining when a patient shall leave hospital to receive home, office or clinic care.

4. Patients hospitalized on general ward services are not charged medical fees ordinarily. When patients are hospitalized on isolation wards for poliomyelitis, however, bills for medical fees are at times submitted. Payment is frequently made by the local chapters of the national Foundation whose treasuries are now generally depleted.

It is hoped that your readers will understand clearly how urgent is our need for cooperation from all practicing physicians in the matters mentioned above.

Sincerely yours,
Hart E. Van Riper, M.D.
Medical Director

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INDEX FOR VOLUME 45

AUTHOR INDEX

In this Index are the names of the authors of original articles which have appeared in the Journal. Subject Index follows.

A

- Allison, J. R.*, A new antihistaminic — chlortrimeton maleate, 344 (Oct.)
Angus, Leslie R., Special school therapy for the problem adolescent, 339 (Nov.)
Arnold, James Harold, the public health problems of hookworm disease in South Carolina, 367 (Dec.)
Ascher, Edward, Psychosomatic medicine—a critique, 113 (April)

B

- Bethca, Oscar W.*, Advances in therapeutics: during the life of the Pee Dee medical association, 29 (Feb.)
Browning, A. W., The general practitioner in rural practice, 155 (May)
Bryan, Williams McIver, Jr., The technic of saddle block analgesia in obstetrics, 8 (Jan.)
Bunch, Charles, Peritoneoscopy, 74 (March)

C

- Cantey, William C.*, Chronic diseases of the thyroid, 303 (Oct.)
Chamberlain, M. D., One hundred years, I (Jan.)
Cook, Weston, New concepts in the management of cerebral palsy, 248 (Aug.)
Cullum, Wilson: See *Seastrunk, J. Gordon*

D

- Dub, Leonard M.*, Modern psychiatry in general practice, 152 (May)
Durham, Robert B., Training of the young doctor, 173 (June)

F

- Fouche, Heyward H.*: See *Zeliff, John E.*

G

- Guess, J. Decherd*, Objectives of a state committee on maternal mortality, 42 (Feb.)
Guess, J. Decherd, Obstetrical lessons from studies of maternal mortality, 335 (Nov.)

H

- Hanckel, Richard W.*, Meningitis of aural origin, 251 (Aug.)
Herbert, W. C., Jr., Hyperparathyroidism, 151 (May)
Hodge, G. B., Platybasia with increased intracranial pressure, 110 (April)
Hodge, G. B.: See *Nelson, James D.*
Hollifield, William C., Echinococcus infection, 359 (Dec.)

J

- Jacobs, Sydney*, Diabetes and tuberculosis, 65 (March)

K

- Katzberg, Arthur J.*, Prolapse of Meckel's Diverticulum with intussusception, 366 (Dec.)
Kinder, E. C.: See *Cantey, William C.*
Kingsbury, Charles H., The Rh factor, 108 (April)

L

- Lippert, Karl Morgan*, Wilms tumor—a report of a six year postoperative cure, 39 (Feb.)

M

- McLauchorn, W. R., Jr.*: See *Herbert, W. C., Jr.*
Means, Royce B.: See *Zeliff, John E.*
Moore, P. J., Jr.: See *Herbert, W. C., Jr.*

N

- Nelson, James D.*, The adrenal medullary tumor syndrome (pheochromocytoma), 70 (March)

P

- Plenge, Henry*: See *Hodge, G. B.*
Pressly, W. L., The doctor in his relationship to his community, 271 (Sept.)

S

- Scurry, R. Brooks*, The use of pentothal as a general anesthetic in vaginal delivery, 10 (Jan.)
Seastrunk, J. Gordon, Histoplasmin sensitivity in Columbia, South Carolina, 37 (Feb.)
Sheehan, Edward B., Carcinoma of the endometrium, 239 (Aug.)
Smith, Hugh, Jr., Multiple myeloma, 175 (June)

T

- Toomey, John A.*, Convulsions in childhood, 338 (Nov.)
Tucker, Arthur W.: See *Sheehan, Edward B.*

W

- Waring, J. I.*, Preventive immunizations of infancy and early childhood, 276 (Sept.)
Waring, Joseph I., Report of the American academy of pediatrics study of child health services in South Carolina, 281 (Sept.); 308 (Oct.)
Weston, William, Jr., Recent advances in diagnosis and treatment of rheumatic fever, 362 (Dec.)
Wiggins, A. L. M., Voluntary cooperative effort, 178 (June)
Wilson, Robert, Jr., The purpuric state, 147 (May)
Wilson, Robert, Jr.: See *Hollifield, William C.*
Wilson, Robert, Tularemia acquired from the bite of a wood-tick, 107 (April)

Y

- Young, J. R.*, Cancer of uterus, 273 (Sept.)

Z

- Zeigler, Rowland F., Jr.*, Saddle block anesthesia in obstetrics: report of 235 consecutive cases, 4 (Jan.)
Zeliff, John E., Ectopic pregnancy: analysis of 100 consecutive cases, 33 (Feb.)

SUBJECT INDEX

This is an Index to all reading matter in the Journal. It is a Subject Index and one should therefore, look for the SUBJECT word, with the following exceptions: "Abstracts," "Book Notices," "Correspondence," "Deaths," "Editorials," "Historical Sidlights" are indexed under these titles at the end of the letters "A," "B," "C," "D," "E," and "H," respectively. The name of the author, in parenthesis, follows the subject entry when it is an original article.

For Author Index see above.

A

- American academy of pediatrics**, report of study of child health services in South Carolina, (Joseph I. Waring), 281 (Sept.); 308 (Oct.)
- Anesthesia**, saddle block in obstetrics: report of 235 consecutive cases, (Rowland F. Zeigler, Jr.), 4 (Jan.)

ABSTRACTS

- Advances in anesthesia, (J. S. Lundy), 46 (Feb.)
- Apical systolic murmur, (A. M. Master), 24 (Jan.)
- Blood loss from donor sites in skin grafting procedures, (D. W. Robinson), 331 (Oct.)
- Bronchiogenic carcinoma, (Evants A. Graham), 331 (Oct.)
- Carcinoma of the lip (J. E. Cross and E. Doland Guralnick), 170 (May)
- Chronic appendicitis and mesenteric adenitis in children, (D. H. Manfredi), 138 (April)
- Early diagnosis and roentgen manifestations of obstruction of small bowel (C. J. Hunt), 136 (April)
- Lumbar puncture headache; brain (G. W. Pickering), 138 (April)
- Polyposis of the colon in children (Jack G. Kerr), 140 (April)
- Postcholecystectomy symptoms due to cystic duct remnant, (C. B. Morton), 299 (Sept.)
- Prenatal diphtheria immunization, (M. A. Brescia and E. F. Tartaglione), 136 (April)
- Reduction of intussusception by barium enema, (M. M. Ravitch and M. McCune, Jr.), 170 (May)
- Streptomycin in the treatment of hemophilus influenzae laryngotracheobronchitis, 200 (June)
- Streptomycin in the treatment of pertussis, (H. Leichenger and A. Schultz), 26 (Jan.)
- Surgical treatment of essential hypertension, (G. de Takats, O. C. Julian, and E. F. Fowler), 331 (Oct.)
- The "buried epidermis," (E. Bors and A. E. Comarr), 24 (Jan.)
- The management of massive gastroduodenal hemorrhage, (F. H. Amendola), 138 (April)
- The prevention of abdominal adhesions, experimental study on the role of gastrointestinal motility, (C. A. Schiff and S. L. Goldberg), 299 (Sept.)
- The use of tripelethamine hydrochloride (pyribenzamine) as a topical anesthetic, (V. Moseley), 299 (Sept.)
- Transfusions in newborn infants through abdominal wall segment of umbilical vein, (Louis R. Pinkus), 24 (Jan.)
- Treatment of non-specific ulcerative colitis for one year with extracts of intestinal mucosa, (Friedman, M. H. F. and Haskell, B. F.) 200 (June)
- Twenty-five easy ways of getting into trouble in the care of fractures, (F. B. Gurd), 170 (May)

B

BOOK NOTICE

- Brown, Lucille, Nursing for the future, 60 (Feb.)

C

- Cancer**, of uterus, (J. R. Young), 273 (Sept.)
- Cerebral palsy**, new concepts in the management of, (Weston Cook), 248 (Aug.)
- Convulsions**, in childhood, (John A. Toomey), 338 (Nov.)
- County Medical Society officers — 1949, 122 (April)

CORRESPONDENCE

- Boone, John A., 102 (March)
- Catheart, R. S., 121 (April)
- Crooks, J. H., 390 (Dec.)
- Furman, Charles C., 236 (July)
- Miley, B. Wessen, 334 (Oct.)
- Stebbins, Ernest L., 103 (March)
- Van Riper, Hart E., 390 (Dec.)
- Wyman, Ben F., 64 (Feb.)

D

- Diabetes and Tuberculosis**, (Sydney Jacobs), 65 (March)
- Doctor**, the, in his relationship to his community, (W. L. Pressly), 271 (Sept.)
- Doctor**, training of the young, (Robert B. Durham), 173 (June)

DEATHS

- Bates, Walter L., 1891-1949, 301 (Sept.); 334 (Oct.)
- Boyd, William Warren, 1881-1949, 301 (Sept.)
- Brailsford, Alexander Moultrie, 1871-1949, 168 (May)
- Catheart, Robert Spann, 1872-1949, 202 (June)
- Cockfield, Reamer Lorenzo, 1884-1949, 268 (Aug.)
- Durham, Isaac Davis, ?-1949, 234 (July)
- Harley, Govan Bragg, 1863-1949, 301 (Sept.)
- Lester, William Evans, 1889-1949, 28 (Jan.)
- Marett, William Clinton, ?-1949, 347 (Nov.)
- Rigby, Cecil, 1891-1949, 168 (May)
- Rudisill, Hillyer, Jr., 1903-1949, 301 (Sept.)
- Sanders, James Oscar, ?-1949, 347 (Nov.)
- Setzler, John B., 1880-1949, 386 (Dec.)
- Smith, Herbert M., ?-1949, 347 (Nov.)
- Smyser, John D., 1888-1949, 96 (March)
- Tupper, Elias Doar, ?-1949, 96 (March)
- Wilds, Robert Henry, 1883-1949, 386 (Dec.)
- Willis, Henry A., 1903-1949, 301 (Sept.)

E

- Echinococcus Infection**, (William C. Hollifield and Robert Wilson, Jr.), 359 (Dec.)
- Ectopic pregnancy**: analysis of 100 consecutive cases, (John E. Zelff, Royce B. Means, Heyward H. Fouche), 33 (Feb.)

Effort, voluntary cooperative, (A. L. M. Wiggins), 178 (June)
Endometrium, carcinoma of the, (Edward B. Sheehan and Arthur W. Tucker), 239 (Aug.)

EDITORIALS

A. M. A. clinical session, 346 (Nov.)
 A. M. A. educational campaign, 280 (Sept.)
 A letter of appreciation, 47 (Feb.)
 A meeting place, 119 (April)
 A rut, 346 (Nov.)
 Alumni post graduate seminar, 48 (Feb.)
 An important letter, 321 (Oct.)
 Annual assembly South Carolina academy of general practice, 372 (Dec.)
 Annual directory, 280 (Sept.)
 Annual meeting, 47 (Feb.)
 Atlantic City sessions, 230 (July)
 Automobile emblems, 320 (Oct.)
 Benjamin O. Whitten, 157 (May)
 Blue shield, 280 (Sept.)
 Blue shield participation, 320 (Oct.)
 Child health services, 320 (Oct.)
 Code of ethics, 254 (Aug.)
 Congratulations and thank you, 78 (March)
 Council, 119 (April)
 Cy O'Driscoll, 372 (Dec.)
 Enrichment of corn meal and grits, 48 (Feb.)
 From our representatives in Congress, 119 (April)
 Honors, 230 (July)
 House of delegates, 78 (March); 119 (April)
 How are our public relations?, 12 (Jan.)
 In England, 78 (March)
 Medical care plan, 183 (June); 230 (July)
 Meeting of council, February 14, 1949, Columbia, S. C., 82 (March)
 Meeting of council, January 16, 1949, 82 (March)
 Membership in county societies, 347 (Nov.)
 National physicians committee, 157 (May)
 New leaders, 119 (April)
 1949 annual session, 183 (June)
 Our new leaders, 183 (June)
 Pediatric seminar, 184 (June)
 Pessimists, 47 (Feb.)
 Public relations, 12 (Jan.)
 Report on the second national conference on physicians and schools, Highland Park, Illinois, October 13-15, 1949, 373 (Dec.)
 Reporting communicable diseases, 230 (July)
 Robert Spann Cathcart, 183 (June)
 School health survey, 157 (May)
 Secretaries and nurses, 254 (Aug.)
 South Carolina state board of health division of cancer control, 373 (Dec.)
 Southeastern allergy association bulletin, September 19, 1949, 373 (Dec.)
 The fight is on, 11 (Jan.)
 The state and the individual, 254 (Aug.)
 Thoughts for the new year, 371 (Dec.)
 To our younger members, 280 (Sept.)

Treatment schedules South Carolina public health hospital, Florence, South Carolina, 184 (June)
 Twenty-five dollars, 11 (Jan.)
 William W. Boyd, 280 (Sept.)

H

Hookworm Disease, the public health problems of in South Carolina, (James Harold Arnold), 367 (Dec.)
Hyperparathyroidism, (W. C. Herbert, Jr., W. R. McLawhorn, Jr., and P. J. Moore, Jr.), 151, (May)

HISTORICAL SIDELIGHTS

The renaissance and some renaissance doctors, (R. M. Pollitzer), 128 (April)
 A history of the society for the relief of the families of deceased and disabled indigent members of the medical profession of the state of South Carolina, (A. J. Buist, Jr.), 85 (March)

I

Immunizations, preventive of infancy and early childhood, (J. I. Waring), 276 (Sept.)

M

Maternal mortality, objectives of a state committee on, (J. Decherd Guess), 42 (Feb.)
Maternal mortality, obstetrical lessons from studies of, (J. Decherd Guess), 335 (Nov.)
Meckel's Diverticulum, prolapse of with intussusception, (Arthur J. Katzberg, M. D.), 366 (Dec.)
Myeloma, multiple, (Hugh Smith, Jr.), 175 (June)

N

News items, 28 (Jan.); 62 (Feb.); 98 (March); 142 (April); 164 (May); 201 (June); 267 (Aug); 298 (Sept.); 333 (Oct.); 386 (Dec.)

O

One hundred years, (O. B. Chamberlain), 1 (Jan.)

P

Pathological conference, 57 (Feb.); 166 (May); 262 (Aug.); 381 (Dec.)
Pentothal, the use of as a general anesthetic in vaginal delivery, (R. Brooks Scurry), 10 (Jan.)
Peritoneoscopy, (Charles Bunch), 74 (March)
Platybasia, with increased intracranial pressure, (G. B. Hodge and Henry Plenge), 110 (April)
Practitioner, the general in rural practice, 155 (May)
 Program of the fourteenth annual Piedmont post graduate assembly, 269 (Aug.)
Psychiatry, modern, in general practice, 152 (May)
Psychosomatic medicine — a critique, (Edward Ascher), 113 (April)
 Public health news, 140 (April); 201 (June); 264 (Aug.); 333 (Oct.)
Purpuric state, the, (Robert Wilson, Jr.), 147 (May)

R

- Report on national health conference, 120 (April)
 Rh factor, the, (Charles H. Kingsbury), 108 (April)
 Rheumatic Fever, recent advances in diagnosis and treatment of, (William Weston, Jr.), 362 (Dec.)

S

- Saddle block analgesia, the technic of in obstetrics, (Williams McIver Bryan, Jr.), 8 (Jan.)
 Sensitivity, histoplasmin in Columbia, South Carolina, (J. Gordon Seastrunk and Wilson Culum), 37 (Feb.)
 South Carolina Medical Association
 balance sheet, 1948, 75 (March)
 officers, 104 (March); 146 (April); 270 (Aug.)
 one hundred and first annual session, 203 (July)
 scientific program, May 17, 18, 19, 1949, 117 (April)
 South Caroliniana, 384 (Dec.)
 Syndrome, the adrenal medullary tumor, (pheochromocytoma), (James D. Nelson and G. B. Hodge), 70 (March)

T

- Ten point program of the South Carolina medical association, 22 (Jan.); 106 (March); 253 (Aug.); 279 (Sept.); 318 (Oct.); 345 (Nov.); 370 (Dec.)
 Ten point program
 A. M. A. considers rural health, 92 (March)
 A. M. A. launches program, 90 (March)
 activities, 126 (April)
 agreement between the South Carolina medical care plan and the participating physician named herein, 324 (Oct.)
 associated medical care plans, 296 (Sept.)
 availability and utilization of medical care in America, 377 (Dec.)
 blue cross program shows progress, 96 (March)
 blue shield adopts contracts, fixes rates, 322 (Oct.)
 blue shield contracts, 374 (Dec.)
 blue shield facts, 256 (Aug.); 288 (Sept.)
 blue shield in Michigan, 292 (Sept.)
 blue shield in rural areas, 296 (Sept.)
 blue shield plans asked to cooperate with A. M. A. national education campaign, 128 (April)
 blue shield plans exceed ten million members in 1948, 127 (April)
 charter issued medical care plan, 255 (Aug.)
 Chicago conferences, 376 (Dec.)
 committee favors department of welfare, 96 (March)
 committee works on fee schedule, 94 (March)
 council approves prepayment plan, 49 (Feb.)
 family doctor of the year, 124 (April)
 federal spending and compulsory sickness insurance, 123 (April)

- fee schedule, 185 (June)
 government and privilege, 18 (Jan.)
 high taxes lowering living standards, 161 (May)
 investigation provokes editorial reaction, 350 (Nov.)
 medical care plan approved, 185 (June)
 medical corps enlistments lagging, 20 (Jan.)
 medical program of the U. M. W. A., 93 (March)
 medical service and socialized medicine, 294 (Sept.)
 naturopathy, 127 (April)
 new committees in state house of representatives, 49 (Feb.)
 opposition to Ewing plan increases, 92 (March)
 physician agreements being signed, 348 (Nov.)
 physicians urged to volunteer for armed services, 94 (March)
 politics and medicine, 161 (May)
 president renews call for compulsory bill, 158 (May)
 report of South Carolina state board of naturopathic examiners, 50 (Feb.)
 report of the council on medical service of the American medical association April 15, 1949, 162 (May)
 rural health, 93 (March)
 social security costs estimated, 164 (May)
 socializing insurance, 380 (Dec.)
 subscriber's certificate surgical contract, 328 (Oct.)
 the cost of medical care, 288 (Sept.)
 the great investigation, 348 (Nov.)
 the high cost of free medical care, 323 (Oct.)
 the Hill bill for voluntary health insurance, 158 (May)
 the impact of socialized medicine on the British physician and his patient, 258 (Aug.)
 the time is short, 15 (Jan.)
 "What Aneurin Bevan told me," 354 (Nov.)
 work on surgical care plan progresses, 127 (April)
 young doctors learn of country practice, 164 (May)
 Therapeutics, advances in: during the life of the Pee Dee medical association, 29 (Feb.)
 Therapy, special school for the problem adolescent, 339 (Nov.)
 Thyroid, chronic diseases of, (William C. Cantey and E. C. Kinder), 303 (Oct.)
 Tularemia, acquired from the bite of a wood-tick, (Robert Wilson, Jr.), 107 (April)
 Tumor, Wilms, a report of a six year postoperative cure, (Karl Morgan Lippert), 39 (Feb.)
 U
 Uterus, cancer of, (J. R. Young), 273 (Sept.)
 W
 Woman's auxiliary, 26 (Jan.); 100 (March); 172 (May); 234 (July); 266 (Aug.); 300 (Sept.); 332 (Oct.); 357 (Nov.); 387 (Dec.)

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